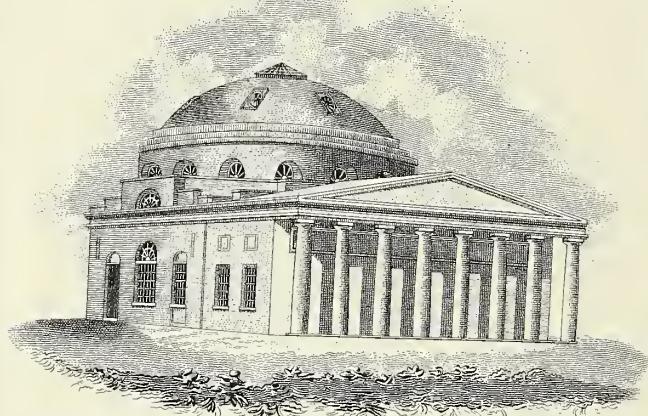




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*The Journal*

OF THE

Kansas Medical Society

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Published Monthly by

THE KANSAS MEDICAL SOCIETY

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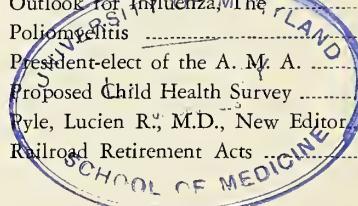
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**THE JOURNAL  
of the  
KANSAS MEDICAL SOCIETY**

*Owned and Published by The Kansas Medical Society*

Volume XLVII

JANUARY, 1946

Number 1

**BEHAVIOR PROBLEMS AND HABIT DISTURBANCES IN PRE-ADOLESCENT CHILDREN: THEIR MEANING AND MANAGEMENT\***

By Robert P. Knight, M.D.

Topeka, Kansas

The greatest possible opportunity for practical mental hygiene lies in the rearing of children. How frequently this opportunity is muffed through parental ignorance is attested by the high incidence of emotional maladjustment, delinquency and mental illness in our youth, both in the armed forces and in civilian life. Fathers who use a high grade of intelligence and judgment in their occupations display an amazing lack of awareness of and incapability for handling the human psychological problems of their children. Mothers who are excellent home managers become baffled by the behavior reactions of their sons and daughters. And teachers, those auxiliary parents to whom we entrust our children for supplemental rearing, except for comparatively few who are alive to their responsibilities for learning and using what has been discovered about human psychology, seem to feel that their duties are adequately discharged in plowing through the daily assignments with as little personal annoyance from their pupils as they can arrange. Why is it that the practical application in child rearing of the now well-known facts of human psychology lags so far behind the application of all other scientific discoveries? Why do we handle human raw material with but a fraction of the intelligence and skill that we habitually employ in developing and handling machines, natural resources, and chemical or electrical forces? And, for that matter, why do we appropriate millions of dollars for the development of non-human materials and forces and skimp like a miser when it comes to spending money for the research study, development, and care of our human resources?

I have raised more questions than I can answer, but before discussing the meaning and management of specific problems in child rearing I would like to dispose of some of the prevalent misconceptions that

stand in the way of utilization of our scientific knowledge about human beings. I wish to call attention to four outstanding misconceptions or practices which lead well-meaning parents and teachers into serious errors with the children they are trying to make into good citizens.

1. *The belief that everybody knows enough about human nature and "psychology" to rear children, advise others on all human difficulties, and "handle people" if he just uses "common sense."* Complacent in this comfortable conviction, people can scoff at psychiatry and psychology and dispense free advice to their friends in dynamite-laden emotional problems whereas they would not presume to offer advice on how to deal with a compound fracture of the thigh or a high fever. "Common sense" is too often the sum total of that individual's own particular experiences and attitudes, narrow vision, collected clichés and misinformation.<sup>1</sup>

2. *The tendency to react to one's own rearing either by copying exactly the disciplinary methods used by one's own parents or else by swinging to the opposite extreme.* Imitation of parents' methods is usually done by those individuals who grew up fairly submissively or who returned to the fold after some sowing of wild oats. Fairly well satisfied with themselves as products of their parents' rearing they apply methods used with them to their children, whether they fit or not, and are nonplussed if they seem not to work. Those individuals who hold unresolved resentments against their parents are likely to try to avoid their parents' mistakes by using indulgence where their parents were strict, liberality where their parents were niggardly, and so on. Neither slavish imitation nor equally slavish avoidance of the old folks' tactics is a sound basis for bringing up a new generation.

3. *The belief that children should be as little nuisance as possible.* According to this theory, the child

\*Reprinted from the Bulletin of the Menninger Clinic, November, 1944.

is, or at least should be, a "little adult" as quickly as one can intimidate him into being docile, clean, quiet, and obedient. Mothers of this school make of toilet training a kind of war of attrition against the child and emerge triumphant with a clean, dry baby at eight months, oblivious to the emotional time-bombs they have planted in his soul. The home is to be a place of order and quiet, with no messes and no bedlam of children's noises. Many teachers have the same idea of managing children. Reduction to a minimum of the annoyance of having the "brats" around can be nicely rationalized into instilling good habits early. Such evidences of barbarism and original sin as "talking back," disregard for property rights and general "orneriness" are to be stamped out ruthlessly by blitzkrieg methods before they get a beachhead established in the child's personality.

4. *The attempt to follow the precepts supposedly emanating from the "new psychology."* In some ways this is perhaps the most tragic misconception in child rearing, for parents who make this attempt are well-meaning seekers of the truth. That they falter and become bewildered and inconsistent is sometimes due to their multiple shifting of the course of discipline after hearing or reading each new idea. Basic principles are missing, and polar opposite methods are simultaneously employed. Having heard that the great danger in bringing up children is causing inhibitions to develop in them which will cripple their lives, they use no discipline, no punishment, no restraint and rear playboys, delinquents and psychopaths. Having heard that parents should be pals to their children, they abdicate their authority as grownups and parents, sacrificing their dignity and their children's respect, in a strenuous but futile attempt to be contemporaries of their children. Having heard that "love" is the most important thing to give the child they give a hovering, over-protective, managerial devotion that is both smothering and devitalizing.

Actually there is no body of theory and fact known as the "new psychology." There is, however, a growing science of human dynamic psychology, contributed to by many different "schools" of psychology and psychiatry, some of the ideas of which have been distorted into false theories of child rearing. The sound principles of dynamic psychology require skillful interpretation and translation into practical advice for parents, and the psychiatrists have perhaps been less adept and effective in this task than some of the lay writers of newspaper columns and books for parents. In the concluding section of this paper I shall attempt to describe a framework of guiding principles for parents and educators, rather than a list of rules covering the innumerable separate issues encountered in child rearing. But first

I should like to discuss what kinds of behavior are to be regarded as more or less normal and inevitable in pre-adolescent children and what kinds are to be considered more serious problems, with suggestions for the management of both.

#### "NORMAL" BEHAVIOR

Children are not "little adults" but a special species of human beings in various stages of evolution from dependence, irresponsibility and bewilderment to some degree of maturity. Adults who have forgotten their own childhood irresponsibility, noisiness, dirtiness, curiosity, dishonesty and resentments toward grownups, or who were processed by strict discipline into "little adults," have a hard time tolerating these normal manifestations in children. A benign tolerance combined with a continuous educative process will keep all of these manifestations within bounds, whereas drastic measures usually increase the difficulty to an enormous degree. Two examples will illustrate this point.

I. A mother gave her six-year-old son five pennies to place in the collection plate at Sunday School. Having no allowance and no other source of money to handle, the boy regarded the obedient deposit of the valuable coins in a plate already containing a lot of money as a great waste. He pretended to put the pennies in the plate but kept them securely palmed. After Sunday School he bought five cents' worth of candy and ate it before going home. It so happened, however, that the Sunday School teacher observed this fall from grace and phoned the mother the sordid story. When the boy arrived home, his mother, already armed with the facts, questioned him casually as to whether or not he had contributed the money as instructed. After leading the boy into a number of incriminating falsehoods she suddenly informed him she knew he was lying and that furthermore he was a thief—the worst kind of a thief, for he had stolen money meant for God's work. She then wept demonstratively over this apparent evidence of early criminality in her son, was unable to eat the Sunday dinner, and retired to her room for the rest of the day. The boy was bewildered and disturbed, but the main lesson he learned was that one has to be more cautious and clever to avoid getting caught. Fifteen years later, after many similar drastic measures, he was forging his father's name to checks, running up large bills on charge accounts which his father had to pay, and lying smoothly while looking the questioner straight in the eye. Had this mother evaluated the childhood incident properly she would have told him at once he had been observed instead of leading him into a lie, would have tolerantly instructed him in the value of honesty and avoidance of trickery, and furthermore would have arranged for a weekly allowance of five or ten cents which he could spend in any way he

pleased. He could lose it, throw it away, spend it all at once or save it; it would have been his to experiment with, and she would have met the child's need instead of seeing crime in *statu nascendi*. Had he been permitted to make his mistakes with pennies and to learn by trial and error and by parental suggestion, the issue in terms of hundreds of dollars and serious criminality very likely would never have arisen.

II. A father, himself in analytic treatment for recurrent depressions, related that his seven-year-old son had proudly shown him an outline drawing of a horse which was far too well done, claiming it as his own sketch. The boy's two-years-older sister actually had considerable talent in drawing and had earned much praise from the parents for her sketches, thus arousing considerable envy in the brother. Oblivious to the child's emotional need, the father viewed the horse with a skeptical eye and asked the boy again if he had really drawn it "free hand" or had traced it. The boy insisted stoutly that he had drawn it. The father then did some detective work until he found the original horse in a magazine and saw that the child's drawing was a tracing. He confronted his son with the evidence, told him he had lied to his father, that lying was very, very wrong and he must be punished. A sound spanking followed. Truth had triumphed, but what of the far more important question of the emotional significance of this incident to the child? Truth can conquer in more subtle ways, too. The father could have recognized that the boy wanted to please him and to be praised by him too, like the sister, and he could have praised him for his excellent tracing. There was no need to raise the issue of *lying* directly. He could then have shown him how to do other kinds of tracing—on the windowpane, with carbon paper, with tissue paper—and have told him that that was a good way to learn to draw. After some practice the boy might have been encouraged to try to draw something without tracing it. Also, other achievements of the boy could have been praised so that he would no longer feel a need to extract praise by deception (if, indeed, the boy had actually intended to deceive).

Most children under seven or eight are unable at times to distinguish truth from fantasy, and often are afraid to tell the truth when questioned about some dereliction for fear of punishment. It is beside the point to corner them on the moral issue of lying. Persistent reality correction, recognizing and meeting their emotional needs, and making the truth easy to tell are much more effective educative methods.

The same attitude should prevail toward the almost inevitable incidents of "stealing" by children—

bringing a playmate's toy home, picking up something desirable at the store, taking money from mother's purse. The toy must be returned, the merchandise taken back or paid for out of the child's allowance money, and patient, continuous instruction in property rights, ownership, and money transactions must be given, but without expressions of horror, the warnings of police and jail, and talk about thieves. At the same time one tries to meet the particular need of the child, indicated by the dereliction, in such a way as to make the dishonest method unnecessary. A regular weekly allowance, increasing gradually and never withheld as punishment, with encouragement to work for pay for the parents and neighbors is an essential educative method.

"Talking back" is one childhood manifestation that many parents feel must be ruthlessly suppressed. It is true that impudence cannot be tolerated and that parental authority cannot be permitted to be challenged defiantly. However, many parents and teachers will not even allow a child to say a word in his own defense, or attempt to explain. Yet under other circumstances than when *they* are offended they urge the child to stand up for himself. The importance of permitting a child to state his case as he sees and feels it, to assert his rights—even toward his parents or teachers—is too great to confuse it with any such false issue as "no talking back." Talking back when fairly permitted, with the parent giving the reasons for his decision, and firmly adhering to it unless he discovers from what the child says that the decision is incorrect and should be modified, does not lead to impudence and defiance. And talking back, in the sense here defined, avoids the intolerable frustration and dammed up resentment which result when the child is both forbidden something and prohibited from saying anything about his feelings.

Every healthy child will feel resentful and aggressive toward his parents at times. He may say it out loud: "I wish you be dead"; "I'm going to run away"; "I hate you"; "I'd like to cut your head off." To become horrified, whip him severely, and send him to his room will only drive this external expression of his resentment inside him to be elaborated in bloody fantasies with consequent fears and guilt feelings. It is much better to be undisturbed and make some such reply as: "I'm sorry you feel that way just because I can't let you stay up longer (or whatever). Mother loves you and knows you won't feel that way very long. Come on now, we have to go to bed." Such a response lets the child know that he cannot *really* hurt his parent with words or thoughts, a very important psychological truth for a child to learn, whereas the parent's violent

reaction to the expressed resentment only makes the aggressive wishes more awesome and real.

Frankly sexual behavior in young children is another manifestation of frequent normal occurrence, but one which often horrifies parents. Childhood masturbation, mutual exposures and examinations of playmates of both sexes, even abortive attempts at intercourse, are only part of the child's curiosity and experimentation in the learning process, and are not evidences of depravity. Far more psychological harm is done by the parents' manifest shock and horror than by the experience itself. Wiser methods include appropriate explanations about sex differences and sex functions and skillful diversion of play into other channels. Children have a hard time reconciling their parents' extreme disapproval of everything sexual with the later discovery that the parents themselves do sexual things with each other and have been doing so all along.

The rest of the usual childhood behavior which is normal, even though it is distressing to parents—noisiness, vulgarity, dirtiness, disregard for good manners and social niceties, irresponsibility, and so on—are best tolerated more or less indulgently while the slow civilizing, educative campaign of child rearing is being consistently carried on.

#### PROBLEM BEHAVIOR

In the last analysis, problem behavior in children represents the result of mishandling by parents of behavior that originally was within normal limits, or the reaction of children to certain traumatic attitudes or conditions in the home, or the effect of certain unfortunate experiences outside the home—or some combination of these. Child behavior becomes a problem when it goes to an extreme, when it persists and develops instead of being a transient manifestation, and when parental ineffectiveness becomes obvious to the child—either because the parents frankly admit and demonstrate their incapability for discipline or because their most drastic methods have failed. Problem behavior may indicate that character development is proceeding in an abnormal direction or it may mean that some kind of neurotic or psychotic illness is developing. Competent professional advice is essential, and treatment of the child, in addition to revised methods according to the advice given, may be necessary.

It is impossible, within the limits of this article, to list and discuss comprehensively the great range of possible problem behavior manifestations,<sup>2</sup> their detailed psychological mechanisms and the best methods for handling every variation. Each case has its individual mechanisms and the methods to be advised must depend on the pertinent factors in that child's experience and home situation and on the degree and persistence of the trouble. However, I shall give a fairly comprehensive list of the most

common disturbances with some comments about each one.

1. *Temper tantrums* are usually more or less calculated, intentional emotional outbursts by a child to gain a point against the parents through a method found to be effective in the past. Crying, screaming, kicking, writhing on the floor—whatever the form they take—has been successful before in influencing the parents to relent in some adverse decision. The obvious answer to this would be for parents never, from the beginning, to be influenced in changing a decision by such behavior. Instead they should meet the behavior firmly, adhering inexorably to the decision made, banishing the child to his own room for cooling off, or, if that doesn't work, administering a spanking then and there. The essential point is to rob the tantrum of its effectiveness and to make it unpleasant. Spanking is by no means a method of discipline condemned by psychiatrists. Its occasional appropriate use may be an essential part of firm, consistent discipline. However, it should not be the first resort, it should be done privately, it should not be a "beating," it should not be done by the father only as his first duty on coming home in the evening and getting the mother's report of the children's behavior for the day, and it should not be done in anger. If the children are confident that they are secure and loved and if they from early infancy have learned to recognize with respect the note of authority in the parents' admonitions and prohibitions, spankings will be necessary very rarely. Other kinds of corporal punishment such as blows of the fists, humiliating face slapping, bearing with sticks, boards, whips, and so on, are condemned as disciplinary methods.

There is a different type of tantrum, described in a recent paper by Dr. Elisabeth Geleerd,<sup>3</sup> which seems to be paranoid in character and requires soothing, mothering and security, but this differentiation must be made after careful study by a child psychiatrist.

2. *Childish tyranny* refers to demanding behavior, insolence, and defiance in a child who is also usually over-dependent. This state of affairs can come about only if the child has gotten the upper hand over a mother who has been too indulgent and spoiling, too solicitous, and lacking in consistent firmness. Consistently refusing to accede to the child's importunate demands, insisting that the child do the things he can do for himself, would have prevented such behavior from developing in most instances. A change to consistent discipline while the child is still small will usually bring such tyranny to an end, but if a child reaches the late teens under such a weak parental regime all the king's horses and psychiatrists may not be able to effect a change.

3. *Timidity and fearfulness*, with associated anxiety spells, nightmares, fears of being away from home or away from mother, may be due to too much parental strictness, usually combined with doing too many things for the child that he should be learning to do for himself—feeding, dressing, bathing, finding his things. His decisions are made for him and he has but to appear helpless to get his mother to do things for him. Occasionally temper tantrums and childish tyranny may be combined with the timidity. To maneuver him out of such a childhood neurosis, the fears and resentments must be uncovered and dealt with by a child psychiatrist and at the same time the mother's attitude must be changed by appropriate re-education and advice.

4. *Apathy, indifference, isolation, inattention and day dreaming* are rather ominous signs at any age, but especially in childhood are they alarming because a healthy child is eager, energetic, curious and alert. Such symptoms represent a kind of withdrawal from the real world of childhood into a fantasy world and foreshadow a developing mental illness unless skillful therapy can draw the child out into normal interests again.

5. *Over-obedience, compulsive neatness and perfectionism* represent a set of reaction formations to rebellious defiance, and while such attitudes may please the undiscriminating parent, trouble usually lies ahead. Such ideals are very difficult to sustain and failure or frustration is almost inevitable. A child with such trends will tolerate failure very poorly, with consequent depression, hopelessness and self-destructive tendencies. The parents can help by not pushing the child further in this direction through over-ambitious expectations and plans, but psychiatric help may be needed to relax these "too good" tendencies.

6. *Cruelty, bullying and over-aggressiveness* may develop out of resentment for the imagined favoring by the parents of a younger sibling or as a result of the child's feeling he is treated in a cruel, rejecting manner by his parents. Aggressive behavior of this kind usually covers many fears and feelings of insecurity. More affectionate management of such a child and taking into account his possible distress at seeing his younger sibling receive care and attention may be sufficient to alter his aggressive attitude. If not, psychiatric consultation should be sought.

7. *Running away* from home or school, where it is not due to real mistreatment justifying such an attempt to escape, may represent a desperate attempt to be independent, to deny the strong need for affection and support from adults. Such behavior is more frequent in adolescence or late pre-adolescence and is usually quite abortive in younger children,

who rather quickly and gladly return home after feeling impelled to carry out a threat to run away.

8. *Frequent accidents and injuries*, such as broken bones, falls with resulting cuts and bruises, gashes from sharp objects may indicate a considerable degree of unconscious guilt with need for self-destructive punishment. Any venturesome child may have occasional accidental injuries, and this heading refers only to those repeated injuries which begin to make one suspect that some purposive tendency exists in the direction of self-injury. A close inspection of the relationship between the child and both parents, as well as between the siblings, or among the child's playmates, may disclose the source of the guilt feelings which are being paid off in this way. Usually this is a transient phase in a child.

9. *Sleepwalking* may be combined with falls and injuries or may occur alone. Many children will sleep-walk during an acute febrile illness, being somewhat delirious at the same time, and transient or occasional sleepwalking, in which the child seems to have difficulty being awakened and appears to be acting out some bad dream may almost be within normal limits. Sleepwalking which persists well into the teens requires psychological investigation to discover and make conscious the impulses and desires being acted out in sleep. Hypoanalysis is often effective in such cases.

10. *Lying* usually develops out of childhood fantasies which are either ignored by the parents or over-reacted to by them with violent attempts to establish truthfulness. Sometimes a child finds that skillful lying gets him into less trouble than telling the truth does. Persistent lying, especially needless lying, up to and past the age of ten is usually accompanied by other types of problem behavior pointing to developing delinquency or mental illness. Treatment in a psychiatric school may be indicated if advice obtained from a psychiatrist and followed consistently by the parents is ineffectual.

11. *Stealing* may result from external influence of companions but this source is probably over-emphasized, for such tendencies must be already present for the external "bad influence" to have any effect. Failure to start early teaching a child how to handle money by giving him an allowance, paying him for special work done, and letting him buy what he wants with what he has, is undoubtedly related to stealing tendencies. Children of four or five should be getting a regular allowance and taking care of their own small funds. If, instead, a parent makes a child ask for money each time he wants something, continuing this into adolescence, there develops a great temptation to steal, first from the parents and later from other people. Of course, factors in the

home ideology, such as the attitudes of the parents about honesty, the family economic status, and group influences in the neighborhood play a part in many cases. A careful survey of all such factors in a psychiatric study is indicated.

12. *Persistent thumb or finger sucking* beyond infancy indicates that the child has come to depend on this device for soothing his anxiety. He may not be able to go to sleep without a finger in his mouth or may automatically put his thumb in when growing sleepy, or on becoming disturbed while awake. Thumb sucking in infants indicates that the child is not getting enough satisfaction of sucking in nursing at the bottle or breast. No direct steps should be taken in infancy beyond increasing the time at the breast or bottle and giving the child more affection. If this does not suffice, pulling his finger out of his mouth after he is asleep, then waiting to pull it out again if he puts it back and continuing this consistently may stop the habit. The main concern later is with possible resulting malocclusion and deformation of the palate.<sup>4</sup> If the cooperation of the child can be enlisted in trying to stop, no punishment being given for failure, but praise being freely given for success, the difficulty can rather quickly be brought under control. Such measures as bitter substances on the favorite finger, gloves, and metal devices over the thumb or at the elbow to prevent bending it are last-ditch measures after everything else has failed, including advice obtained from a child psychiatrist.<sup>5</sup>

13. *Nail biting* also represents a way of reducing anxiety and may evolve out of earlier thumb sucking. Similar measures to those described in No. 12 should be tried. In girls the cosmetic appeal is often effective.

14. *Persistent enuresis or soiling* after the age of three indicates a psychosexual conflict of considerable degree. Any child may have some occasional relapse in wetting or soiling, especially in reaction to some disturbing event, such as the birth of a new baby, a death in the family, separation of the parents, being left with a nurse while the parents take a trip, and so on. But persistent wetting or soiling in the absence of such special traumatic events requires careful scrutiny of the whole setting and all the child's relationships by a competent child expert. Punishment or shaming by the parents should never be done, but control of fluid intake after the evening meal, getting the child up again when the parents retire, and praise for dry nights may be sufficient.

15. *Excessive or open masturbation* refers to almost constant handling of the genitals, with erections in boys, sometimes done in the presence of others while seemingly oblivious to their presence. One would almost certainly find other disturbances also in such a child—perhaps apathy, distractibility

and states of preoccupation. Punishment and shaming are again contraindicated, and the underlying conflict should be sought with the help of a child psychiatrist.

16. *Fire setting* in children can develop into a serious matter and requires prompt management. Invariably other behavior disturbances and psychosexual conflicts will be found to be present. Psychiatric advice should be sought and a complete psychological examination done, followed by the type of treatment and management indicated.

17. *Persistent transvestism* refers to frequent or habitual wearing of girls' clothes by boys or vice versa. The latter has far more social acceptance than the former so that transvestism in boys represents a greater deviation from normal behavior. The wish to be a girl—identification with mother or sister—underlies such behavior, and feminine mannerisms and interests may be associated. Using of fingernail or toenail polish, or posing and dancing before a mirror clad in girls' dresses or undergarments may be carried on secretly, and other perverse tendencies, such as fetishism, may be present. Parents interested in the normal development of their child will not let this go, believing complacently that the child will outgrow it, for later on it will be more firmly fixed and the whole personality development goes along in key with the transvestism. Psychiatric help is essential here.

#### CONCLUSION

Child rearing is a very specialized and complicated occupation, proficiency in which is not conferred on a couple when they get married. Parents who are themselves immature and unstable will inevitably have problem behavior in their children, while parents who may be mature in most ways may have, for psychological reasons arising out of their own experience, unfortunate attitudes of antagonism and intolerance toward the "annoyances" of normal child behavior, or misconceptions and distorted theories about how to rear children.

Education for parenthood should be incorporated in the curriculum of secondary schools and colleges. Courses in mental hygiene and dynamic psychology should include sound psychological principles of child rearing so that this enormously important factor in the future mental health of the new generation is not left to chance, ignorance and the parents' own "common sense." Similar courses for prospective teachers outrank in importance the instruction in teaching subject matter.

Children, in the vast majority of instances, will develop normally if the following conditions are present:

1. Consistent, real affection from both parents so that the child feels wanted and secure. Such real

affection will mean that the parents also want the child to develop independence, and have individuality and rights.

2. Consistent, firm, united discipline from both parents, carried out with reference to the child's needs rather than to the parents' comfort. All children need such parental disciplinary restraint to protect them from feeling anxious and helpless in relation to their own instinctual drives.

3. Sufficient understanding of, tolerance of, and ability to identify oneself with children to permit sensing what the child needs and what he is trying to accomplish by his various struggles and techniques. A few persons seem to develop this nat-

urally as a product of their own experience and psychological-mindedness; others need to read and study intensively in order to be adequate to the parental responsibility.

4. Willingness on the part of the parents to seek counsel and help from competent child psychiatrists when problems arise which are beyond the parents' understanding.

1. For a powerful indictment of this kind of "common sense" see pp. 9-14 of *The Human Mind* by Dr. Karl Menninger.

2. For a comprehensive discussion see pp. 139-176 of *Common Neuroses of Children and Adults* by Dr. O. Spurgeon English and Dr. Gerald H. J. Pearson.

3. *Some Observations on Temper Tantrums in Children* by Dr. Elisabeth Geleerd. To be published in the American Journal of Orthopsychiatry.

4. Authorities disagree about the seriousness of this possibility.

5. Many psychiatrists would say "never."

## USE OF PENICILLIN OINTMENT IN TREATMENT OF IMPETIGO AND OTHER CONDITIONS OF THE SKIN

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Impetigo Contagiosa is an acute superficial infection of the skin in which the lesions are discrete, thin-walled bullae. They begin as localized erythematous areas which become vesiculated, itch and form an exudate which dries and forms yellowish crusts. They differ as to size and shape, may appear singly or in crops and may coalesce. They may be annular or serpiginous with healing in the center.

The condition has been treated with a number of previously known methods with success and we have now another procedure, which, in our experience has shown excellent results. Heretofore the use of silver nitrate, gentian violet, five per cent sulfathiazole ointment and the following prescription

Ol. Rusci	0.6
Starch	
Talc	aa
10 per cent Ammoniated	1.5
Mercury	30.0

have all been successful but each has presented its drawbacks. (1) Ten per cent silver nitrate causes discoloration of the skin and if repeated often enough, destroys the dermis. (2) Two per cent gentian violet in water is sometimes considered by the patient as unsightly, while we have found some people sensitive to the use of sulfathiazole and a contact dermatitis has resulted. An occasional patient is sensitive to mercury, but of the above methods of treatment, we feel the prescription of ammoniated mercury to be the best. The other ingredients of the ointment are used for their ad-

hesive qualities so that the mixture remains on the lesions to do its work. Preceding the application of the ointment the use of clorox solution (one dram to a glass of water) to cleanse the lesions is very beneficial.

We wish to submit at this time the use of a penicillin ointment which we feel offers great possibilities in selected cases. The ointment we have used is prepared by dissolving a packet of penicillin powder in petrolatum alba. The amount used is 30,000 Oxford units of the drug in one ounce of the petrolatum. This is applied quite easily by the patient at home twice daily, and is not messy, greasy or disagreeable to use but serves somewhat as a cold cream. It does not stain or leave any ill effects as far as we have been able to tell with the 21 cases we have had under our observation.

Another method of preparing the penicillin is to dissolve 30,000 units of the drug in one ounce of aquaphor base and use this in the same way as the above ointment. It has yielded us even better results.

The duration of the impetigo seemed to make no difference in the cure as our cases ranged in duration from five days to nine weeks, all of which responded in from three to seven days of penicillin ointment application. The ages of the patients we treated ranged from three years to twenty-two years.

In addition to this use of penicillin for impetigo, we have used it for the treatment of syphilis vulgaris, infected ringworm of the scalp, generalized furunculosis, secondarily infected malaria of the axillae, infected eczema of the ears and for an ulcer of the glans penis. In one case of syphilis vulgaris

we found the condition to be aggravated by the use of the penicillin ointment and resorted to other means of treatment.

Penicillin ointment can be used to advantage in the treatment of generalized furunculosis. It is especially good in furunculosis in infants where the scalp, body or anal regions are involved. The following case of a six-months-old baby illustrates the success of the treatment.

Case 1—B.B.—infant, age 6 months. The scalp and head were covered with furuncles of varying sizes which the baby had had for one week. There was hardly an area that one could lay a dime on without resting it on a painful furuncle. The only treatment given was the twice daily application of the penicillin ointment. In five days the child's

head and scalp was as normal as that of any other child its age.

#### CONCLUSION

1. We feel that five per cent sulfathiazole ointment is as effective as penicillin were it not for the danger of sensitivity.

2. Penicillin ointment is remarkable in its effects on impetigo, generalized furunculosis and skin infections and superior to any other method tried. We have had only two reactions.

3. Penicillin ointment is particularly effective in its use on infants with furunculosis of the scalp or peri-anal regions.

4. Aquaphor or a similar water soluble ointment has been found by us to be superior to the petroleum as a vehicle in which to incorporate penicillin for local administration.

## TUBERCLE BACILLI IN GASTRIC CONTENTS

Examination of gastric contents for tubercle bacilli in the fasting patient, while a routine procedure among children at Muirdale Sanatorium since its inception, has only gradually been extended to adults. The now demonstrated importance of the procedure in aiding diagnosis, in guiding therapy, and in the evaluation of the patient before discharge has come to be recognized rather slowly.

Examination of gastric contents for tubercle bacilli is used by the author on all patients who deny raising sputum or whose sputum is negative. It is also used in cases where there is doubt as to the source of the sample presented. Since a single negative gastric aspiration is not considered conclusive, repeated aspirations are performed at intervals. Some patients have cultures of both sputum and gastric contents. Such a procedure expedites the diagnosis of cases with suspected active lesions.

The material used for examination consists of undiluted gastric contents aspirated from fasting patients the first thing in the morning. Previous to 1941, culture and guinea pig inoculation were done simultaneously on all specimens. Since that time only cultures are used since they are very accurate and the difference in the results of the two procedures did not warrant continued use of the guinea pig. All specimens are cultured on three slants of Petragnani's medium, and contamination is reported when all three tubes are involved, an infrequent occurrence.

One cannot rely on smears of concentrated specimens of gastric contents for the detection of tubercle bacilli—the number of positives is always small. In certain diagnostic cases animal inoculations, in addition to cultures, are necessary.

The patient who has negative sputum cultures,

but who has tubercle bacilli only by gastric examination, is not a so-called innocuous patient. In our survey we observed 21 such patients who on subsequent sputum examination were positive on concentrated smear or culture. Therefore, these patients can and do develop subsequent positive sputum. A patient with a positive gastric content should be treated exactly like a patient with a positive sputum.

Before the author's patients are discharged it is necessary that they have negative gastric aspirations in the absence of sputum. This is done to avoid the discharge of active cases. In order for a patient to be discharged with medical advice as inactive he must have at least five successive negative examinations. If negative on those examinations, and if other findings warrant it, the patient is discharged as having no evidence of active disease.

During the past five years, 868 adults at Muirdale Sanatorium had a total of 4,204 examinations of gastric contents. Of these, 404 (46.4 per cent) had negative gastric contents; they received 1,338 examinations. The remaining 464 (53.6 per cent) cases had 2,866 examinations, of which 1,271 (44.3 per cent) were positive. The number of examinations per case varied, the average for the negative group being 3.3; for the positive group 6.2 per case. The number of repeats depends upon the individual case, just as in sputum examinations.

Thus there are two groups of patients—those with positive and those with negative contents. Each of these groups in turn is divided into three subgroups: The no-sputum group, the negative-sputum group and the positive-sputum group.

No fine line of distinction can be drawn between these three subgroups. Occasionally patients deny raising sputum and yet the specimen they send in

contains tubercle bacilli. Also, there are patients who state they raise sputum, when the sample is only saliva, or secretions from a chronic nasopharyngitis common in the locality. It is realized that, if numerous and timely sputum examinations were done, a small percentage would have proved positive. This is not deemed economically advisable, as valuable time may be lost. Instead, a simple reliable gastric aspiration can be done with culture results known in a few weeks.

Significantly, 21 out of 282 patients (7.5 per cent) became sputum-positive after being positive at first only on gastric aspiration. This occurred on the average of about six months later. This small group of patients reveals an important fact because, as has been previously pointed out, these cases cannot be considered as harmless, and careful observation and timely sputum examinations will find that some of these cases are sputum-positive.

It is important to do consecutive gastric examinations on adult patients in whom it is impossible to determine the status of activity from a roentgenogram and in whom the sputum, if present, is negative. If five consecutive aspirations are negative on culture, it is most likely that there is no evidence of active pulmonary tuberculosis.

Of the 404 patients in our series who never had a positive gastric aspiration there were 224 who had either no sputum or negative sputum. In spite of the diagnosis of pulmonary tuberculosis on admission the author feels justified in recording a case as having no evidence of active tuberculosis if a series

of gastric aspirations is negative as well as sputum cultures.

The remaining 180 of the 404 with negative gastric contents had, at some time, tubercle bacilli in the sputum. The main reason that there were no positive aspirations in this group is because, in most of these patients, the examinations followed by some ten months a positive sputum, and many of these cases were on the road to recovery.

It is possible, however, to have a negative gastric content and a positive sputum, which does not invalidate the reliability of this procedure. There were several patients who became gastric-content-negative and sputum-negative and then later became sputum-positive. Unstable cases of tuberculosis are likely to fluctuate like this.

In the past year and one-half it has been the author's policy to do five consecutive aspirations on negative cases. If these examinations are negative by culture, the individual is considered as having no evidence of active pulmonary tuberculosis. In the majority of cases it is wise to hold these patients for observation until the cultures are completed. Of the cultures, over 95 per cent, where positive, will show growth within six weeks. However, the cultures are kept until eight weeks. The patient is then re-x-rayed and his case is reevaluated. Most of these are discharged with no clinical evidence of active tuberculosis.

*The Significance of Tubercle Bacilli in Gastric Contents, David D. Feld, M.D., The American Review of Tuberculosis, December, 1944.*

### New Journal of Hematology

A new bimonthly scientific publication, "Blood—The Journal of Hematology", will appear in January, devoted exclusively to the field of blood and blood-forming organs. Editor-in-chief of the periodical is Dr. William Dameshek, Boston, and associate editors are Doctors Charles A. Doan, Columbus; Thomas Hale Ham, A.U.S.; Roy R. Kracke, Birmingham; Nathan Rosenthal, New York; and Maxwell W. Wintrobe, Salt Lake City. Dr. George R. Minot, Boston, is consulting editor.

The primary aim of the journal is to give further impetus to the newer dynamic approach by which American hematology has forged beyond the predominantly morphologic European concepts. It will stress the practical relation of hematology to all other branches of medicine and will present articles by foremost authorities on anemias, transfusions, plasma, the Rh factor, and latest developments in therapy.

### Sectional Meeting in St. Louis

A sectional meeting for fellows of the American College of Surgeons in the states of Missouri, Kansas, Illinois, Indiana, Kentucky, Arkansas, and Oklahoma will be held January 31 and February 1 at the Jefferson hotel, St. Louis. There will be scientific sessions, medical motion pictures, a clinical conference, demonstrations, and panel discussions.

### Veterans' Administration Now Recruiting

In a recent letter to the Executive Office Lt. Col. A. R. Pearce, chief medical officer, advises that the central office of the Veterans' Administration, Washington, D. C., is now recruiting and assigning to duty Associate Medical Officers and Medical Officers who meet the requirements of the current civil service announcement.

Salaries for associates range from \$3,640 to \$4,300 per annum for a 40-hour week, and for medical officers from \$4,300 to \$5,180. Additional amounts of \$421.66 and \$396.33 per annum are now being paid since the Veterans' Administration is currently on a 44-hour week.

Complete details of the requirements may be secured from the central office.

### Need for EENT Papers

The Portuguese Society of Ophthalmology has asked that reprints of papers on EENT subjects be forwarded to Lisbon in order to build up a library for use of its members, and Dr. L. R. Haas, Smith Clinic Building, Pittsburg, Kansas, who presented the request to the Journal, reports that no reprints have been received to date. Any Kansas physician who can contribute to this library may do so by sending two reprints to Dr. Haas.

## PRESIDENT'S PAGE

*To the Members of the Kansas Medical Society:*

May I wish you a year of achievement both for you as individuals and for the society as a whole. Following the signing of the peace treaties, medical officers are returning to the individual practice of medicine and a place of leadership in the affairs of our society. Those members who remained at home during the war will anticipate with relief the return of the men from the services. Together, it is our hope to make 1946 outstanding in the history of Kansas medicine.

In the spring the first post-war meeting of the Kansas Medical Society will be held in Wichita. The presence of a large number of scientific exhibits, the appearance of an outstanding group of guest speakers, and a larger attendance than ever before will make this occasion a memorable one and one in which we hope every member will participate.

As the year began, the Kansas Physicians' Service went into effect. Twenty-one groups are now enrolled and more will follow even before this is published. Already residents of Lawrence, Garden City, El Dorado, Topeka, and many other places have availed themselves of this protection. 1946 will see Kansas Physicians' Service grow to become an influence in our attempt to maintain the individual practice of medicine. This year will see Kansas Physicians' Service unite with a national health plan to make pre-paid medical care benefits available throughout the state. In 1946 arrangements for an agreement with the Veterans' Administration will also be completed, thus giving the Kansas veteran the selection of his own physician for the care of his service-connected disabilities. Within a few days a formal announcement of this project will be sent to you and we hope you will give it careful consideration.

On Friday, January 11, dedication ceremonies of Winter General Veterans' Hospital were held in Topeka. The Army has released it to the Veterans' Administration, and a school of psychiatry is to be established there which will train doctors, nurses, social workers and others interested in this work. The faculty is now being selected, and the members will come from all over the United States as well as foreign lands. Kansas medicine is to be congratulated on the fact that the Veterans' Administration has recognized the profession and that Winter General Hospital has been transferred from the Army to the Veterans' Administration for training purposes. We want to urge all members of the society to get behind the staff and welcome them to Kansas medicine.

This year will bring a crisis regarding the socialization of our profession. The ultimate result depends upon our unity and the quality of medical work rendered the people of this state. Of the last we have no fears, but we should remind ourselves that the society's attempt to equalize distribution and cost of medical care will have an important bearing on our future.

If freedom of enterprise still exists for the doctors of medicine when 1947 arrives, it will exist because the profession has effectively answered its critics by effective action on the points mentioned above. Achievement is within our grasp if we are willing to unite our efforts during 1946.



President

## EDITORIALS

### Medical Care for Veterans

The Kansas Medical Society takes pride in being the first state society to complete arrangements with the Veterans' Administration on a plan whereby the veteran may receive medical care by the physician of his choice outside an established Veterans' Administration hospital. Credit for this achievement goes entirely to the president, W. P. Callahan, M.D., who spent a great deal of time and effort on this project.

In the fall Major General Paul R. Hawley invited the presidents of medical societies to negotiate with the Veterans' Administration regarding ways in which doctors in private practice might give care to veterans. Dr. Callahan immediately took advantage of the opportunity and after two extended visits in Washington and approval of the plan by the Council made a formal announcement to the Society in the December issue of the Journal.

Under the agreement, the Kansas Medical Society will prepare two lists of physicians for the Veterans' Administration. The first will be a list of doctors qualified to give general examinations for those veterans who apply for pensions. The second list will consist of doctors who will give specialized examinations. The state will be divided into small areas so that services may be rendered in the veteran's own locality.

According to this agreement, medical care will be given by the physician of the veteran's choice in cases where emergency treatment is necessary and in instances where care is required for a service-connected disability or a disability aggravated by service if the veterans' hospital is filled.

The Veterans' Administration will set up an office in Topeka adjacent to or near the Executive Office of the medical society. A doctor trained in regulations applying to the Veterans' Administration will be in charge of this office and will act on all reports and claims resulting from this work. The Kansas Medical Society will cooperate with the Veterans' Administration in an effort to provide for the veteran the finest possible medical care with a minimum of delay and confusion.

This is an opportunity for the doctors of Kansas to provide a service to the veterans of the state. It may well become an experiment to determine whether private practice shall survive. If a government agency can contract with a medical society to the mutual advantage of all parties concerned, then the individual practice of medicine will have achieved prestige in the eyes of the Congress. Should

the plan fail, it will then be cited as proof of the inadequacy of the present system of medicine.

The challenge is now directed to the individual physician who will provide the service. The veteran welcomes the opportunity of selecting his doctor and is pleased with the plan. He will, however, become critical more rapidly than the average patient because his expenses are being paid. The challenge, therefore, to the physicians of the state is important. It is sincerely hoped that all doctors will cooperate. In this way he will assist the veteran, and at the same time will establish an overwhelming argument in favor of continuing medicine as it is practiced in the United States today.

### Socialized Medicine

Attend a gathering of doctors and soon you will hear a discussion on socialized medicine. Whether it is a private group or a national conference is of little importance for the pattern seldom varies except that in a national body you derive a dubious comfort from learning that the problem is not yours alone.

What variation there is may be found in proposed solutions, but even here thought is beginning to crystallize. At one extreme will be found advocates of appeasement who contend that a democratic government is beneficent and that a program of the greatest good for the greatest number must be supported even by the minority. At the other extreme are those who propose tacit resistance to any encroachment of personal liberties by refusing to render service. The poles are represented then by conformists and by rebels.

Somewhere between these extremes may be found the mass of physicians who have devoted their lives to keep people well and who are now bewildered by the implications that they have not done enough. Included in this group are physicians of all ages, service men and civilians, whose opinions are converging to the effect that a solution is possible. From all parts of the country comes evidence that the medical profession can offer the benefits proposed by the government at less cost and on a voluntary basis.

Criticism that the medical profession has no answer to social planning except in the negative is no longer valid. Constructive programs are in effect and in many areas already beyond experimental stages. Kansas' initiative in plans of medical care for the indigent serves as an example. So must the voluntary pre-paid medical care plans all over the nation. These non-profit corporations, with Kansas Physicians' Service among them, give protection against the cost of medical care and are proving their soundness and their popularity wherever they are tried. The doctor is providing the

answer to socialized medicine by eliminating its need.

And somehow the doctor today is finding his voice. He is speaking to the public in words that the layman can understand. He is taking the average citizen into his confidence and is dispelling various misconceptions. These are important and might be paraphrased without radical distortion.

The doctor is first of all a citizen of the United States and a doctor of medicine second. He is not less interested in the welfare of this nation than is the laborer or the business executive. Therefore, he is more concerned about democracy than about socialized medicine. Recalling from history that every totalitarian power began with the socialization of medicine, he sees this as an enormously greater threat than its apparent features imply. He calls to the nation no longer in plaintive tones of self-preservation but in the interest of retaining the freedom on which this nation was founded. And the nation is beginning to listen.

### DDT

Before DDT became available to the public, many very enthusiastic reports about the drug appeared in the daily press. Later there were many reports of its extreme toxicity which were somewhat exaggerated. F. C. Bishopp, assistant chief, Bureau of Entomology, United States Department of Agriculture, recently summarized the present views of the department.

DDT (dichloro-diphenyl-trichloroethane) was synthesized in 1874 by a German student, Orthmar Ziegler. It remained on the shelves until the Swiss firm of J. R. Geigy tested it for use as a moth proofing agent and to kill houseflies and found it definitely insecticidal. In 1942 the Geigy company sent a sample of the drug to the United States where it was submitted to the U. S. Department of Agriculture for evaluation.

Bishopp<sup>1</sup> describes the experimental work done in this country, field trials in North Africa and the curbing of a typhus epidemic at Naples by DDT used as a dusting powder. Since then it has been prepared in various mixtures as dusts, sprays and aerosols. The drug is soluble in a number of organic solvents including chloroform, xylene, kerosene and other petroleum oils. The liquid preparations have been used for application by spraying from airplanes and as little as one quart of oil containing five per cent DDT to the acre will kill all the larvae and adults of the common malaria mosquito. The insecticidal effect of DDT persists for several months after it is sprayed on wood, canvas or vegetation and in the case of flies, the killing effect lasts even longer. If fences, buildings and vegetation around

fly breeding places are sprayed, the flies will be killed as they emerge from their puparia and crawl over the treated objects. Bedbugs, rat fleas, ticks, sandflies and mites are killed by DDT. The drug is toxic to cockroaches, but the standard sodium fluoride or pyrethrum treatments are more effective. In the future we have reason to hope that DDT can and will be used to destroy the insect vectors of many diseases such as malaria, Rocky Mountain spotted fever, typhus, encephalomyelitis, yellow fever, dengue, relapsing fever, filariasis, kala azar, verruga, pappataci fever and other diseases in which insects carry disease organisms such as flies in food borne dysenteries.

If an insecticide is to be used extensively, it should not be toxic to man and forms of life beneficial to man. DDT acts as a nerve poison when ingested or absorbed, but its toxicity to warm blooded animals varies. The oral lethal dose ranges from 200 to 500 mgm. per kilogram of body weight. Severe tremors develop from sublethal doses. Bishopp concludes that "DDT is much less dangerous to man and higher animals from direct toxic action than are many other insecticides, but it should be handled with care, especially to avoid ingestion and prolonged contact of oil solutions with the skin." There are no toxic results when ten per cent of DDT in pyrophyllite is dusted on the skin. Poultry appear to be more susceptible than mammals, but snakes, toads and frogs may be killed by dosages in the insecticidal range. Fish are markedly susceptible, especially this is true of trout. They may be poisoned by eating insects which have been killed by DDT, floating on the surface of water. Therefore there is more experimental work to be done before the drug can have widespread use as a spray covering large areas of land.

1. Bishopp, Fred C., Bull. N. Y. Acad. Med., Nov. 1945.

### Review of Basic Sciences

The committee on Postgraduate Study of the Kansas Medical Society and the director of the Graduate School of the University of Kansas are anxious to learn the number of men in the state who would be interested in a review of the basic sciences, especially pre-clinical. The review is designed for physicians who have completed the necessary residency requirements and contemplate taking national boards.

The proposed review will be in one or two parts of five days each, covering basic subjects such as anatomy, chemistry (both bio and clinical), pathologic physiology, pathology, and pharmacology. It will be scheduled for some time in the spring of 1946, at a cost ranging from \$50 to \$100.

Physicians interested in this type of course are asked to write to Dr. E. H. Hashinger, University of Kansas Hospitals, Kansas City, Kansas.

Hemorrhage is the most common gastro-intestinal complication of typhoid fever.—C. H. Hodgson, M.D., in Proceedings of the Staff Meetings of the Mayo Clinic.

## EXECUTIVE OFFICE

### National Health Congress

Historically the meeting will be recorded as the first annual conference of presidents and other officers of state medical societies. The time was Sunday, December 2, 1945; the place, Chicago. It will be remembered by those present for the fact that Arthur J. Altmeyer spoke his views and that John F. Hunt answered him.

Splendid addresses were given by doctors from various states, but the occasion was memorable because two laymen took over the battle. Mr. Altmeyer is the chairman of the Social Security Board in Washington, D. C. He has many times previously announced his interest in government sponsored medical care and once more at this meeting declared health to be a national problem that can be solved only on a national scale and on a basis of compulsory participation.

Mr. Hunt answered. Mr. Hunt is vice president of Foote, Cone and Belding, a prominent advertising agency which previously made the public relations survey for the Michigan Medical Society. (See Executive Office, Journal of the Kansas Medical Society, February 1945). Here follows a resume of the paper Mr. Hunt presented at Chicago from notes taken at the time.

"You reject the Wagner-Murray-Dingell bill but your rejection is a flat refusal to have anything to do with it. Yet of all the people, you are most interested in the purpose of this bill for you devote your lives to keeping people well. You want a proper spread of medical care but unless you achieve that, the public will take it from the government for the public knows the value of health.

"Today the public prefers the voluntary plan, but it has no choice on a national basis. Today the only national plan for general medical care is the Wagner-Murray-Dingell bill. In the face of this crisis, you throw out a lot of negative arguments and belligerent words which in the end will avail you nothing.

"Too many doctors try to put out a five-alarm fire with squirts from their hypodermic needles. Each gust of Washington air fans the fire that much higher, and you had a beautiful gust on November 19. Let us be realistic! You don't cure your patients by merely diagnosing their ailments and then putting off treatment, nor can you do that here.

"Today a National Health Congress is proposed. Even though it is still an idea, this is the plan as it now stands.

"It represents a voluntary merging of all voluntary health plans, thereby making available to everybody benefits that are now restricted by state and county boundaries. On a voluntary basis this will increase the quality of medical care because it represents a coordination of the abilities and facilities of the medical profession.

"You are the tools that must be used by anyone (yourselves or the government). Now you can build your own house or the government will build it for you and, incidentally, run it for you. If you elect to do this yourself, the people will be for you, and therefore the government will be for you, for in the last analysis the government is the people.

"The National Health Congress is also an organization. It will be composed of 387 members, one seat for each senatorial and representative district in the United States and one for the United States Public Health Service. On the roster will be doctors of medicine, dentists, nurses, hospital administrators, pharmacists, etc., representing pro-

fessional services. Business, labor, government, agriculture must also be seated in the Congress if a truly national representation is to be achieved.

"A large organization like this cannot be in session over extended periods but could be called together for annual meetings. In the interim, committees would be active. These could be divided by states and coordinated on a national level. They would embrace all topics of interest to the Congress and individually be responsible to the executive staff and ultimately to the entire body.

"Business has already approved a move in this direction and will cooperate. If labor is given a just place in the plan, you will find it singing in your choir instead of its strident solo in the other chorus. And the general public will approve as soon as they have assurance that they are partners. People do not want to be tools used to engineer the designs of selfish doctors."

In conclusion Mr. Hunt warned. "Somebody will start this thing. It should be you. But you must take action now for the time is short."

Already there has been introduced into the Senate a resolution to draw up an International Health Organization to operate under the United Nations organization. Therefore, the time is probably even shorter than it seemed to be on December 2. This preliminary report is offered, as are all items in this column, without comment, merely for your consideration. In the future much information will be received on the subject and then or now your comments are invited.

### Menninger Foundation School of Psychiatry

The winter quarter of the Menninger Foundation School of Psychiatry opened January 2, 1946. Twenty-seven physicians are enrolled in the three-year program of general psychiatric education leading to certification by the American Board of Psychiatry. This program, which developed from resident training at the Menninger clinic, was announced for the opening of the School of Psychiatry, October 1, 1945. In the year 1946 the school will expand considerably in collaboration with Winter General Hospital, which the Veterans' Administration has taken over from the Army in order to assist in the establishment of a psychiatric training center. Dr. Karl Menninger, director of the school, has been appointed temporary manager of Winter General hospital to facilitate cooperation of the two institutions.

An even balance of supervised clinical assignments and didactic instruction is maintained in the educational program. Throughout the course, Fellows of the School of Psychiatry devote one half their time to the examination and treatment of patients and the other half to lectures, seminars, case conferences, reading in the professional library, and individual instruction. Clinical facilities include the service of the Menninger Psychiatric hospital, the outpatient departments for children and for adults of the Menninger clinic, the Southard school, and the different services of Winter General hospital. A rotation system of clinical assignments insures well rounded training for all Fellows of the school.

Qualified physicians accepted for fellowships in the School of Psychiatry by the Education Committee of the school are eligible for training positions in Winter General hospital, to which only Fellows of the school are appointed. Of the 27 physicians now enrolled, 22 are veterans, most of whom became devoted to their interest in psychiatry as a result of assignment to NP service.

April 1, July 1 and October 1 are the opening dates of the spring, summer and fall quarters.

## KANSAS PHYSICIANS' SERVICE

On December 12, 1945, after an examination of the books and the records, Mr. Charles F. Hobbs, commissioner of insurance for the state of Kansas, granted a certificate of authority to Kansas Physicians' Service. This gave final approval to the corporation, placed it in operation, and brought to an end three years of planning and preparation.

At the time this is written, Mr. Sam J. Barham, executive director of Kansas Physicians' Service, has mailed out more than 10,000 descriptive pamphlets, has answered innumerable letters, and has enrolled groups of which the Journal World at Lawrence, Kansas, was first. Kansas Physicians' Service has become a reality, and the first benefits under this program will be effective as of January 1, 1946.

Since sending the physicians of Kansas descriptive material, the Board of Directors made changes which will liberalize certain portions of the subscription agreement and, it is hoped, will make them more satisfactory to the physician as well as the patient.

Employed groups may enroll under Kansas Physicians' Service and purchase subscription agreements either separately or in conjunction with Blue Cross hospital protection. In general, 50 per cent of the employees in any group must participate, except that at least five must enroll, and for groups under 20 the percentage is greater than 50.

The subscriber will pay 90 cents a month if single and \$2.25 a month if married. The family subscription rate will include all benefits for the husband, the wife, and all unemployed children under the age of 19 years. The family rate applies also to a husband and wife without children because potentially that category presents the most expensive type of subscriber. Many will be young couples who will utilize benefits provided for obstetrical services. Most of the others will be elderly couples whose medical costs will be high.

The patient will select the physician of his choice and Kansas Physicians' Service will pay the physician according to the regulations contained in the subscription agreement. If he is a participating physician, i.e., one who has signed a contract with Kansas Physicians' Service, 100 per cent of the fee schedule will be paid. If the physician is licensed by the Kansas State Board of Medical Registration and Examination but is not a participating physician, a service charge of five per cent will be deducted before payment is made. If the physician is a doctor of medicine licensed in another state, he will be paid 75 per cent of the fee as listed in the schedule of benefits.

If the patient selects a participating physician and the participating physician believes that person to be earning less than \$1,800 a year if single or \$2,400 a year if married, then services rendered under the Kansas Physicians' Service will entail no additional cost to the patient. In other words, the participating physician has agreed in those instances to accept the designated fee as full payment for services rendered under the subscription agreement. If the individual's income is greater than those amounts in the opinion of the physician, the regular fee will be charged and the patient will receive an indemnity of the amount stipulated by the schedule of benefits toward the total. Here again nothing is done to disturb the private practice of medicine except to guarantee to the lowest income group that their benefits will represent service.

Upon enrolling, the subscriber will become eligible for the following benefits:

1. SURGERY: It is intended to cover all surgical procedures whether performed in the hospital, in the doctor's office or in the patient's home, with the exception that tonsillectomies, adenoidectomies, and elective surgery for conditions known by the patient to have existed prior to enrollment cannot be performed under Kansas Physicians' Service until the subscriber has been enrolled for eight consecutive months. If a pre-existing condition becomes acute within the first eight months of membership, except for tonsils and adenoids, surgery done under those conditions will be paid for.

2. OBSTETRICS: Benefits will be paid for services rendered whether in the hospital or elsewhere, for subscribers who have been enrolled under a family membership for eight consecutive months prior to expected normal delivery. Interrupted pregnancies, if normal delivery was not expected during the first eight months of membership, will be paid for.

3. FRACTURES AND DISLOCATIONS: Benefits are payable whether care is given in the hospital or elsewhere. Following accidents, diagnostic x-rays up to \$15 per year are allowable.

4. NON-SURGICAL ILLNESS: The patient is eligible for medical care beginning with the fourth day of hospitalization and for 30 days thereafter. The attending physician will be paid \$5.00 for care for the fourth day of hospitalization and \$3.00 per day thereafter and, if more than one call per day is required, an additional \$1.50 is allowable if approved by the Executive Committee. The exceptions are that patients with functional, nervous, or mental disorders, tuberculosis, or diabetes are not eligible for care for these illnesses at any time.

The non-surgical benefit was carefully studied before the present plan was adopted. Kansas is one of very few states that has included non-surgical benefits at all. The requirements of hospitalization and the three-day waiting period are necessary to avoid frequent payments for minor illnesses. Should such conditions be included, the cost would be greatly increased.

5. OTHER BENEFITS: Consultation fees will be allowed if approved by the Executive Committee. Anesthetists will be paid according to the fee schedule in all cases where anesthesia is required. X-ray benefits are limited to accident cases only and to \$15 per year.

In general then, Kansas Physicians' Service is attempting to prevent financial embarrassment occasioned by the high cost of catastrophic illness. For the low income group that suffers most, it undertakes to offer a service contract and yet give to the doctor adequate fees for his services. For the upper income group, the physician will continue to charge his regular fees and the subscriber will receive an indemnity.

The Kansas Medical Society is offering this as a service to the people of this state and thereby is cooperating with other states in an effort to eliminate the necessity of the Federal government entering the field of medicine. It is urged that all members of the Kansas Medical Society become participating physicians so that this may rapidly become a project of the entire Society. Participation will also benefit the individual physician who is asked to care for subscribers. Additional participating physician agreements are available at the Executive Office and will be mailed upon request.

## Narcotic Regulations

According to information received from the district supervisor of narcotic control in Kansas City, Missouri, there has been considerable disregard for Federal narcotic regulations. If inspectors surveyed the state and filed judgments in the court for violations of the Harrison Narcotic Act, many Kansas physicians would be embarrassed. War time pressures and physician shortages have made it difficult for the doctor to comply with all regulations, but regardless of the inconveniences that might be occasioned and emergencies that might exist, the federal inspector of narcotics is not at liberty to justify any relaxation of requirements.

The Harrison Act and its application to a physician who uses narcotics in the practice of medicine is brief and easily understood. Of importance at this point is the fact that local situations, regardless of their urgency, cannot alter the requirements imposed by Federal law.

The Harrison Act states that an order must be filed for the sale or transfer of all narcotics except that physicians, authorized by state law to dispense narcotics, may write individual prescriptions if the product is used for medicinal purposes. Such prescriptions must contain identifying information, the physician's signature in ink or indelible pencil and must be filed with the dispensing pharmacist at the time of delivery. The druggist is required to keep these prescriptions on file for a period of not less than two years. Refills for preparations containing narcotics must not be delivered unless another prescription is filed.

In Kansas doctors of medicine, doctors of dentistry, and doctors of veterinary medicine are permitted to dispense narcotics provided the individual is properly registered with his Board of Examination. For the medical profession, this is the Kansas State Board of Medical Registration and Examination. Dr. J. F. Hassig, Huron building, Kansas City, Kansas, is secretary of the board. Federal narcotic licenses will not be issued to doctors in Kansas unless they have first received licenses to practice medicine and surgery in this state.

This is emphasized to explain to returning medical officers that delay will be occasioned in obtaining a narcotic license unless the state license is first reinstated. By action of the Board, the annual registration fee from members in the armed forces was waived. During that time the state license was declared to be inactive. Upon returning to civilian practice, medical officers should immediately request the reinstatement of their licenses and send to the Kansas State Board of Medical Examination the annual registration fee of one dollar. After that, the Federal narcotic license may be applied for and obtained.

The Federal law makes no mention of telephone orders. Prescriptions phoned to the druggist cannot legally be dispensed to the patient. By refusing latitude in this regard the Division of Narcotic Control serves to protect the doctor. Addicts have been known to call druggists, pretending to be doctors, and have obtained narcotics in this way.

The physician who needs narcotics for general use should write an order for those and will continue to dispense from this supply as he has in the past. There are instances when prescriptions are not necessary, but they apply only where preparations containing small amounts of narcotics are compounded or where the physician actually administers the drug in the course of treatment. Physicians who dispense narcotics must keep a record of these transactions if narcotics are left for the patient to take.

The Journal wishes to call these regulations to the attention of each doctor in Kansas. If an inspector finds that narcotics have been issued to patients without signed prescriptions, the pharmacist and the doctor may be charged

jointly in Federal court and both will be made principals in the case.

## 1946 Annual Session

The first post-war annual session of the Kansas Medical Society will be held in Wichita from April 22 to April 25. After an interruption caused by the war, a full scale session will be held this year. Interest among physicians has been heightened because many medical officers from Kansas will have returned and because physicians who remained in civilian life will welcome this opportunity for graduate education.

Interest among exhibitors is greater than before because many products developed during the war years have not been brought to the attention of the medical profession in this state. It is anticipated that the technical exhibits will represent a larger group of companies than has ever shown in Kansas before. We invite all members of the Society to take advantage of this opportunity to renew acquaintance with established and reputable firms and to learn from their representatives of the advancements that are contemplated or now in production.

Members are especially invited to contribute material for the scientific exhibits. During the war, pressure of work made it difficult for a doctor to prepare exhibits of this nature. Now, however, interest in scientific exhibits is being revived, as illustrated by indications that scientific exhibits will arrive from many areas of the state. A special invitation is here forwarded to all members of the Society to contribute toward this portion of the annual session. Any doctor having scientific material that might be displayed at this session should notify Dr. A. E. Hiebert, Wichita, chairman of the committee on scientific exhibits, and space will be reserved.

The committee on the scientific program has planned to obtain a group of nationally prominent speakers. Papers will be varied to include material of interest to each member of the Society. Announcements will be made as soon as final acceptance has been obtained. For the present, however, it is assured that the program will be outstanding and long remembered by everyone who attends.

Entertainment will be provided in the form of a golf tournament on Monday afternoon, April 22, and a dinner in the evening. Other social events will be held throughout the week. The annual banquet will feature a speaker of national reputation who will talk on a subject of interest to the wives as well as the doctors.

Hotel accommodations are at a premium and should be arranged for well in advance of the meeting dates. The three largest hotels in Wichita are ready to take reservations at present. It is recommended that everyone planning to attend the annual session this year make reservations at this time. Should you be unsuccessful in obtaining hotel rooms, kindly notify the Executive Office.

The Sedgwick County Medical Society will be host and has been preparing for months to offer a program that will be of value and of interest to all doctors in the state. Suggestions are welcome and may be sent directly to any of the following committee chairmen:

- J. E. Wolfe, M.D., General Chairman.
- J. S. Reifsneider, M.D., Scientific Program.
- J. L. Beaver, M.D., Commercial Exhibits.
- A. E. Hiebert, M.D., Scientific Exhibits.
- B. P. Meeker, M.D., Arrangements.
- A. L. Ashmore, M.D., Reception.
- R. H. Maxwell, M.D., Publicity.
- H. R. Hodson, M.D., Entertainment.
- C. C. Brown, M.D., Woman's Auxiliary.

### Vocational Rehabilitation

The Kansas Division of Vocational Rehabilitation represents a service to the people of Kansas. This department has facilities to train, to rehabilitate, and to find employment for persons who are physically handicapped. It is estimated that there are 53,000 people in this state with permanent physical disabilities, many of whom are unable to earn a living. This group is eligible to apply to the Vocational Rehabilitation Division for assistance.

An investigator surveys the financial need and plans the program for each individual according to the situation. If financial assistance is necessary, the division can provide for aid. Training may also be given to assist the client in becoming gainfully employed. This program is not started until aptitudes as well as the disability have been carefully evaluated. The next phase of the program involves finding permanent employment.

Before any case is accepted, a physical examination is made. The patient selects his own doctor who, as a result of the examination, evaluates the handicap and recommends to the rehabilitation division the type of work that the patient might do. If the examining physician believes that the handicap may be reduced, he recommends medical care.

Such recommendations are then forwarded to the medical consultant. If, after a second examination, it is believed that medical care can benefit the patient, this care is authorized and given. Training and employment for the patient are then provided after medical care has been completed.

The medical consultant for the division is C. R. Rombold, M. D., Wichita. The Advisory Committee consists of doctors of various specialties selected from all parts of the state. The complete list is available at the Executive Office and may be obtained upon request.

Mr. Harry M. Dawdy of Topeka, director, points out that the program represents a benefit to the handicapped persons in the state and that it is also an economy. The average cost for each case cared for by the Vocational Rehabilitation Division is \$250, a non-recurring expenditure contrasting sharply with the \$300 to \$500 required each year to maintain dependent persons at public expense. The following article written by Mr. Dawdy explains in more detail the physical restoration portion of this program.

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By Harry Dawdy, Director, Division of Vocational Rehabilitation,  
State Board for Vocational Education

We have long believed that the vocational rehabilitation axiom should be, "Never train around a disability that can be remedied." Medical authorities have agreed that tackling the complex problem of vocational rehabilitation without including physical restoration services is putting the cart before the horse.

The way is now clear to enlist medicine, surgery, and the auxiliary professional specialties, along with vocational guidance and training, for a realistic attack on the problems of disablement. The administration of this program rests with the State Board for Vocational Education and the State Board of Social Welfare.

In co-operation with the Kansas Medical Society, a Professional Advisory Committee composed of medical men representing specialties most likely to be encountered in vocational rehabilitation has been selected to advise the boards regarding the establishment of the criteria to be followed in the administration of the program. Stated in brief, these plans cover the following integral factors, all or part of which may be required for successful rehabilitation:

1. Location of persons in need of rehabilitation to allay

the disintegrating effects of idleness and hopelessness.

2. Medical diagnosis and prognosis, coupled with a vocational diagnosis, as a basis for determining a complete individual plan.
3. Vocational guidance to select suitable fields of work by relating occupational capacities to job requirements and occupational opportunities in the community.
4. Medical and surgical treatment where such treatment will substantially reduce or eliminate the handicap.
5. Physical and occupational therapy and psychiatric treatment as a part of medical treatment when needed.
6. Vocational training to furnish new skills when physical impairments incapacitate for normal occupations.
7. Financial assistance to provide maintenance during training when the need exists.
8. Placement which will afford the best use of abilities and skills in accordance with physical abilities and individual temperament.
9. Follow-up on performance in employment to afford adjustments that may be necessary to keep the individual on the job.

Physical examination, counseling, guidance, training, and placement are available to all citizens of Kansas who are permanently disabled. Medical treatment, transportation, hospitalization, maintenance, and instructional supplies are provided the individual on the basis of financial need. All plans involving physical restoration services are subject to the approval of the Medical Consultant.

Physical restoration services must be such as may be expected to substantially reduce or eliminate an employment handicap. Treatment may be given only for conditions which are "static." It is clear that this term was intended by the Congress and the Legislature to differentiate the conditions to be treated under this program from ordinary acute illness or injury. Hospitalization is limited to a period of ninety days. This limitation was clearly intended to distinguish our program from those providing long-term care for chronic illnesses.

The State Boards are constantly seeking the advice of the medical and allied professions through their Professional Advisory Committee. It is evident that the medical work in rehabilitation will often be of a specialized character, and in work of this type, it is of the utmost importance that standards be established that will assure the handicapped medical services of high quality. A prudent use of public funds demands this.

### Secretaries Return from Service

The medical societies of two neighboring states have announced the return from service of their executive secretaries. Harvey T. Sethman, who served as a major in the medical administrative corps of the Army, has returned to his duties as executive secretary of the Colorado State Medical Society and managing editor of the Rocky Mountain Medical Journal, and R. H. Graham, recently relieved of active duty as an Army captain, has returned to a similar position with the Oklahoma society.

### Pediatric Antiques on Tour

The famous Mead Johnson collection of pediatric antiques is now on its annual pilgrimage to colleges, hospitals, museums, libraries and other institutions. Arrangements for "stopovers" may be made by application to the curator, Mead Johnson and Company, Evansville 21, Indiana.

# "Smoothage" IN THE CONSTIPATION OF PREGNANCY

The constipation frequently encountered during pregnancy, due to pressure of the fetus on the pelvic bowel, lack of exercise, and restricted diet, is alleviated by Metamucil.



The Smoothage of Metamucil encourages easy, gentle evacuation. It does not interfere with the absorption of vitamins or other food factors:

"Smoothage" describes the gentle, nonirritating action of Metamucil—the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

**METAMUCIL** is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois



# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

### Refresher Course at K.U.

A complete program of the postgraduate refresher course in physical medicine, to be offered by the University of Kansas School of Medicine, January 21 through January 25, has been announced.

A number of prominent guest instructors will take part, and the courses will include studies in the uses of physical therapy and occupational therapy in general practice and small hospitals. Plans for organizing, equipping and using a physical medicine department will be discussed. In addition to observation of actual treatments at the University Hospital, those enrolled for the course will have an opportunity to observe the work in physical medicine being done in other hospitals in the Kansas City area.

The following program has been arranged:

Monday, January 21.

Dr. Edward H. Hashinger, Chairman.

8:00 a.m.—Registration

9:00 a.m.—Methods of Applying Heat. Dr. Gordon M. Martin, Mrs. Ruth Monteith.

10:00 a.m.—Discussion of the Basic Principles of Therapeutic Exercise (Part I). Dr. Earl C. Elkins.

11:00 a.m.—Recess.

11:30 a.m.—Experiences in Rehabilitation in the Army. Dr. Howard A. Rusk.

12:30 p.m.—Luncheon.

Dr. Thomas G. Orr, Chairman

1:30 p.m.—The Discriminating Use of Massage. Dr. Gordon M. Martin, Mrs. Ruth Monteith.

2:30 p.m.—Basic Principles of Therapeutic Exercise (Part II). Dr. Earl C. Elkins.

3:30 p.m.—The Problems of the Doctor, the Veteran and the Community. Dr. Howard A. Rusk.

Tuesday, January 22.

Dr. Clarence J. Weber, Chairman.

9:00 a.m.—Electrotherapy: (a) Low Voltage Currents in Diagnosis and Treatment. (b) Clinical Uses of Ultra-Violet and Infra-red Energy. Dr. Gordon M. Martin, Mrs. Ruth Monteith.

10:00 a.m.—Muscle Strength Testing and Its Significance (part I). Dr. Earl C. Elkins.

11:00 a.m.—Recess.

11:30 a.m.—Evaluation of Arthritis in Reference to Treatment. Dr. Nicholas S. Pichard.

12:30 p.m.—Luncheon.

Dr. Tom R. Hamilton, Chairman.

1:30 p.m.—Muscle Strength Testing and Its Significance (Part II). Dr. Earl C. Elkins.

2:30 p.m.—Peripheral Vascular Disease. Dr. M. M. Rumold.

3:30 p.m.—Principles of Practical Hydrotherapy. Dr. Gordon M. Martin.

Wednesday, January 23.

Dr. Ralph H. Major, Chairman.

9:00 a.m.—Demonstration of Manual Muscle Testing. Dr. Earl C. Elkins.

10:00 a.m.—Clinical and Electro-diagnostic Studies in Neuromuscular Diseases. Dr. A. Theodore Steegman.

11:00 a.m.—Recess.

11:30 a.m.—Occupational Therapy: Where? How? Why? Miss Marie Franciscus.

12:30 p.m.—Luncheon.

1:30 p.m.—Physical Rehabilitation of the Severely Disabled with Special Reference to Spinal Cord Injuries and Poliomyelitis. (Part I). Dr. Earl C. Elkins.

2:30 p.m.—Cerebral Palsy: Symposium. Dr. Herbert C. Miller, Chairman.

Medical and Social Aspects—Dr. Herbert C. Miller.

Orthopedic Measures—Dr. James B. Weaver.

Intelligence Evaluation—Miss Margaret Ivy.

Physical Therapy—Miss Margaret Wylie.

Occupational Therapy—Mrs. Alice Clark.

Speech Therapy—Miss Quintilla Anders.

Educational Program—Miss Nelle Cummins

Thursday, January 24.

Dr. John H. Wheeler, Chairman.

9:00 a.m.—The Problem of Backache: Diagnosis and Management. Dr. James B. Weaver.

10:00 a.m.—Physical Rehabilitation of the Severely Disabled (Part II). Dr. Earl C. Elkins.

11:00 a.m.—Recess.

11:30 a.m.—Practical Applications of Occupational Therapy. Miss Marie Franciscus.

12:30 p.m.—Luncheon.

1:30 p.m.—General Indication for and the Prescription of Therapeutic Exercise. Dr. Earl C. Elkins.

2:30 p.m.—Treatment of Poliomyelitis. Discussion and Demonstration of Currently Accepted Methods. Dr. Gordon M. Martin, Mrs. Ruth Monteith, Miss Naomi Wesson.

3:30 p.m.—Occupational Therapy Clinic. Actual Observation of work being done in an Occupational Therapy workshop. Mrs. Nina Crawford, Miss Phyllis Riggs, Miss Marie Franciscus.

Friday, January 25.

Dr. Gordon M. Martin, Chairman.

9:00 a.m.—Speech Therapy: Discussion and Demonstration of Principles Involved in Treating Stutterers and other speech defectives. Miss Quintilla Anders.

10:00 a.m.—Physical Medicine in the Small Hospital. Dr. Frank H. Krusen.

11:00 a.m.—Recess

11:30 a.m.—The Painful Shoulder, Its Diagnosis and Management. Dr. James B. Elliott.

12:30 p.m.—Luncheon.

Dr. Gordon M. Martin, Chairman.

1:30 p.m.—The Use and Abuse of Bed Rest, Dr. Frank H. Krusen.

2:30 p.m.—Physical Medicine Clinic. Demonstration of Applied Physical Medicine in the Hospital Physical Therapy Department.

The faculty will include the following guest instructors:

Frank H. Krusen, M. D., Professor of Physical Medicine Mayo Foundation, University of Minnesota. Head of Section on Physical Medicine, Mayo Clinic. Director of the Baruch Committee on Physical Medicine.

Howard Rusk, M.D., Associate Editor of New York Times. Consultant on Physical Rehabilitation for the Baruch Committee. Formerly Chief of the Convalescent Division, Office of the Air Surgeon, U. S. Army.

Earl C. Elkins, M.D., Section on Physical Medicine, Mayo Clinic, Rochester, Minnesota.

Miss Marie Franciscus, O.T.R., Chief of Occupational Therapy, Crile General Hospital, U. S. Army, Cleveland, Ohio.

Miss Nelle Cummins, Principal of the DeLano School for Crippled Children, Kansas City, Missouri.

Miss Margaret Wylie, R.P.T., Director of Physical Therapy, DeLano School for Crippled Children, Kansas City, Missouri.

Mrs. Alice Clark, O.T.R., In Charge of Occupational Therapy, DeLano School for Crippled Children, Kansas City, Missouri.



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### Postgraduate Course in Pediatrics

A postgraduate program in pediatrics will be given at the University of Kansas School of Medicine, Kansas City, Kansas, February 25 to March 1 inclusive, under the auspices of the Division of Graduate Medical Education of the school, the Kansas State Board of Health, and the Child Welfare committee of the Kansas Medical Society.

The following out-of-state speakers have been procured:

Dr. Paul Boisvert, assistant professor of pediatrics, Yale Medical school.

Dr. Ethel Dunham, formerly director of the Division of Research, Children's Bureau, Department of Labor, Washington, D. C.

Dr. Harry Gordon, assistant professor of pediatrics, Cornell Medical School.

Dr. Robert Sears, director, Iowa Child Welfare Research station, University of Iowa.

The Kansas State Board of Health is paying Kansas physicians who wish to attend, a stipend of \$50 to cover travel and living expenses. Since the number of stipends is limited, applications for stipends will be granted in the order that they are received.

A more complete program of the course will be announced in February.

### Study Release of Medical Personnel

An exhaustive study of the release of Army doctors and dentists in the European theater is now being made by personal representatives of the Secretary of War, reports Major General Norman T. Kirk, Surgeon General. A similar investigation was recently completed in the Pacific.

The investigators have been given full power to make a complete investigation of all pertinent facts so that necessary steps to expedite the return of doctors can be taken. They will determine the necessary medical and dental strength so that all surplus professional men can be released or assigned to replace doctors who are eligible for release. The highest transportation priority will be arranged to speed up the program. The investigators will also make recommendations for the immediate correction of situations involving undue delay in returning doctors who have been declared surplus.

Another phase of the study will be the determination of the number of hospital beds needed to meet present conditions in Europe.

An investigation is also planned in this country to see that staffs are cut as rapidly as their work loads permit.

In the meantime, the Surgeon General announces that a total of 15,469 doctors had been released up to November 30, which is in excess of the 13,000 quota set for the end of the year.

### Psychiatric Personnel Placement Service

The American Psychiatric association and the National Committee for Mental Hygiene jointly announce the appointment of Capt. Forrest M. Harrison (MC) U. S. N., as director of a newly established Psychiatric Personnel Placement Service. The service is designed especially to help physicians and psychiatrists make contact with training opportunities such as residencies, postgraduate courses and fellowships, and to aid institutions in locating suitable candidates for appointments.

Physicians interested in psychiatry are invited to send in full biographical statements including personal data, education, training, experience and special desires, in order that this service may be of the greatest possible assistance to them. Inquiries should be addressed to Capt. Forrest M. Harrison, National Committee for Mental Hygiene, 1790 Broadway, New York 19, New York.

### Death Notices

#### FREDERICK C. TYREE, M.D.

Dr. F. C. Tyree, 62, a member of the Republic County Medical Society, died at his home in Agenda November 24. A graduate of the University of Kansas School of Medicine with the class of 1906, Dr. Tyree practiced in Wayne until May, 1943, when he moved to Agenda.

#### OPIE W. SWOPE, M.D.

Dr. Opie W. Swope, 64, well known radiologist of Wichita, died at a Wichita hospital December 12. He was a graduate of the Maryland Medical College, Baltimore.

Dr. Swope was a member of the Sedgwick County Medical Society, the American Board of Radiology, the Radiological Society of North America, Inc., and the American College of Radiology.

#### F. E. DARGATZ, M.D.

Dr. F. E. Dargatz, practicing physician in Kinsley for the past 25 years, died at Bethel hospital, Newton, November 30. He had formerly practiced in Macksville and had served in the medical corps in France during World War I.

He was a graduate of the University Medical College of Kansas City with the class of 1913, and at the time of his death was an active member of the Edwards County Medical Society.

#### CHARLES W. ROBINSON, M.D.

Dr. Charles W. Robinson, 55, died of pneumonia at his home in Atchison December 20. He had been inactive since suffering a stroke of paralysis in 1934, but had retained his membership in the Atchison County Medical Society.

He was graduated from Kansas Medical college, Topeka, in 1913 and began practice in Atchison in 1916. For 18 years he served as county physician.

#### O. N. CLARK, M.D.

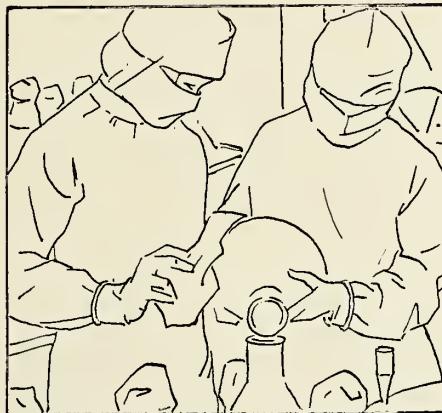
Dr. O. N. Clark, 59, died at his office in Greeley December 7 following a series of heart attacks. He was a member of the Anderson County Medical Society and had practiced at Vesper, El Dorado, and Lane before going to Greeley 12 years ago. He was a graduate of the Eclectic Medical college of Kansas City.

#### ROSCOE C. LEINBACH, M.D.

Dr. R. C. Leinbach, 61, president of the Pottawatomie County Medical Society, died at his home in Onaga December 14 after a lingering illness. A graduate of the University Medical College of Kansas City in 1907, he first practiced at Homewood and Berryton, locating in Onaga in 1919. He was chairman of the county medical examining board during the past war, and had been surgeon for the Union Pacific since 1933.

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## THE KANSAS PRESS LOOKS AT MEDICINE

### Better Doctoring

Kansas doctors finally have worked out the details and hope to have in actual operation by the first of the year their program of what might with equal accuracy be termed either doctor insurance, group medical care, or mildly socialized medicine.

Under the plan any family for a premium of \$2.25 a month will be able to receive all the surgery, obstetrical care, treatment of injuries, or doctoring of the more serious illnesses from almost any doctor it chooses. It is a sound plan which will enable many families to receive the medical care they previously have not been able to afford, and the state's MDs are to be congratulated for placing it in operation. It has one major defect, though. It doesn't go far enough.

The premium, of course, would have to be high enough to cover the averaged cost, but the group medicine program should be broad enough to cover the things about which one more frequently calls a doctor. The program also should cover advice on what to do when Junior swallows a penny, when grandma has a stomachache, when papa hits his finger with a hammer, and when little sister doesn't seem to be breathing quite right. It should even hold out an occasionally comforting hand to the inevitable hypochondriacs.

But those refinements can come later. The important thing is that a beginning has been made in providing adequate, competent medical and surgical care as a financial possibility for the many instead of holding it as a luxury.—*Hutchinson News-Herald, November 23, 1945.*

### Doctors Are Concentrating

It isn't too far-fetched to say that the rural areas in a few years may find themselves back where their pioneering grandfathers were as far as access to medical care is concerned. The old doctors are passing and the young docs are tending to congregate in larger centers. Right now, there are families in the Pratt area who are 25 miles from the nearest doctor and the chances of their ever having a physician in their nearest small town seems rather remote at this time.

Meeting this situation is another one of those knotty problems. The best solution appears to be in getting hard-surfaced roads into every community. With adequate highways and good cars, no family need be more than half an hour's time from a doctor. Establishment of health centers has been proposed but this will only further centralize medical facilities.

Unless the trend to concentrate medical skills, which recently has been given a boost by the Veterans administration is halted, rural areas will have to either keep themselves in a high state of health or provide for rapid communication between their homes and medical men.—*Pratt Tribune, December 7, 1945.*

### Army and Doctors

There are 80 army doctors for 430 patients at Scott Field, Ill., it was disclosed this week. In Parsons, perhaps a typical community as far as civilian physicians are concerned, there is one doctor for every 2,000 persons.

An investigation at Scott Field revealed, among other things, that four specialists have five patients to look after. One medical man said he had performed "virtually

no work of any kind in the last two months—there simply isn't anything to do."

In light of the facts an air corps medical general admitted a "temporary" surplus at the field and said that "approximately 50 per cent of the medical officers will be either released from active duty or transferred to other stations within 90 days."

That statement means next to nothing as far as relief for the undermanned civilian medical personnel is concerned. The general, in true army fashion, uses a lot of words in saying not much of anything. His statement could be taken to mean that half of the doctors at the field will be released in the next three months—or it could mean that half of them will be kept in the service and transferred to other posts.

But giving the uniformed spokesman all the benefit of the doubt, there still would be left some 40 doctors for 430 patients at the field—a ratio of 1 to 10, compared to 1 to 2,000 or more in civilian life.

The army has been extremely dilatory in its handling of the medical personnel problem. So has the navy. It is this kind of thing which aggravates the public and undermines its confidence in the armed services. Never before in peace years do the army and navy so need the support of public opinion. But hardly ever before have they flouted the public interest as they are now doing in the case of thousands of doctors sorely needed in private practice. Their attitude is well nigh incomprehensible.—*Parsons Sun, December 15, 1945.*

### Luke Warm Enthusiasm

As one who believes in the necessity of making medical care available to everyone through either some sort of insurance program or a system of public aid, I hate to greet the plan evolved under the auspices of the *Kansas Medical Association* and now placed in operation with luke-warm enthusiasm. A study of it, however, permits no other reaction. It is a step in the right direction. But it is such a tiny, timid one.

The plan provides for the formation of groups whose members can receive limited and enumerated services from any physician or surgeon they choose at a family rate of \$2.25 a month. In a general way the services offered are those necessary following a serious accident, operations, obstetrical care and those called for after one is sick enough to have been in a hospital three days.

The group approach is excellent. The monthly payment is swell. The free choice of practitioner is admirable. But the program must be heavily discounted by one obvious and one apparent defect.

The obvious defect is that the program provides only for the exceptions and ignores the stomach aches, measles, unlocatable pains, chickenpox, and minor maladies which might prove serious but seldom do, all of which make up the far greater part of the average family's doctor bills.

The apparent defect is that the association has leaned too far backward for its own financial protection in setting its monthly charge. Were this a private insurance company establishing the plan such prudence would be admirable. Inasmuch, however, as a public service is the primary concern, it would have been wiser to have experimented with the minimum rather than the maximum estimated fee in order to popularize the plan.

A start has been made, however, and even with these reservations it is deserving of support. Time may evolve the program into the widely beneficial arrangement it could be.—*Hutchinson News-Herald, December 12, 1945.*

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## MEMBERS

Dr. John A. Grove, who has been serving as a lieutenant colonel in the Army in England, has returned to his work at the Axtell clinic in Newton.

Dr. Mary Glassen, Phillipsburg, was elected vice president of the National Women's Medical association at a meeting held in New Orleans in December.

Capt. Eugene Reeves, Army surgeon, is now on terminal leave and will resume his practice in Kansas City this month.

Dr. E. J. Schulte, who has been serving in the Army for the past three years, has returned to his home at Girard and is resuming his practice there.

Dr. L. L. Bresette, Kansas City, was elected president of the Kansas City Southwest Clinical society for 1946 at a meeting held December 10. Dr. O. W. Davidson, also of Kansas City, was made a member of the board of directors.

The Rice County Medical Society has announced the return to civilian life of three of its members who have been serving in the Army, Dr. R. E. Bula and Dr. E. R. Hill of Lyons and Dr. Harold Patterson of Bushton.

Dr. Walter Pertijohn, who has been practicing in Kiowa for the past eight years, is moving to Russell and will practice with Dr. F. S. Hawes and Dr. F. N. White.

The city of Ottawa reports the return of three of its doctors who have been in the service, Dr. J. R. Henning, Dr. J. F. Barr, and Dr. J. E. Wallen. Dr. Henning, the first physician from Ottawa to enter the Army, spent 35 months in the service, including duty above the Arctic circle. Dr. Barr, who served as a commander in the Navy in the South Pacific, will reopen his office soon. Dr. Wallen, who was released from the Navy this month, plans to resume his practice soon. During his military service Commander Barr was senior medical officer on the attack transport Lavaca.

Commander John W. Hertzler has been discharged from the Navy and is resuming his connection with the Bethel clinic, Newton. While on active duty he spent 21 months in the Pacific in fleet hospital No. 106 and aboard the U. S. S. Pathfinder, and during the past year he served at the hospital at the Charleston navy yard.

Dr. R. A. Clark and his wife, Dr. Margaret G. Clark, have opened an office in Lawrence. Dr. R. A. Clark, who served in the Army for five years, has just been released from the service, and prior to that time had practiced in Kansas City. Dr. Margaret Clark, who plans to specialize in obstetrics and diseases of women and children, has been serving in St. Margaret's hospital in Kansas City while her husband was in the Army.

Dr. S. B. Muller is planning to open his office in Pittsburgh when space is available. During three years service in the Navy as a lieutenant commander, Dr. Muller spent 17 months overseas, in Australia, New Guinea and the Philippines. He formerly practiced in Scammon and was taking

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special work at the Royal Oak hospital, Royal Oak, Michigan, at the time war was declared.

Dr. Harold W. Powers is returning to his practice in Topeka this month after 40 months absence while serving in the Army, 19 months with the 185th general hospital in England. Dr. Powers, who held the rank of lieutenant colonel, was chief of the EENT service at the hospital.

Major Raymond A. Schwegler will soon return to his practice in Lawrence after three and a half years of military service as head of the department of obstetrics and gynecology at Fort Sam Houston, Texas.

Dr. E. A. McClintock, who has been serving in the Army medical corps in England, has announced the opening of his office in Topeka. Dr. McClintock will specialize in internal medicine and neuropsychiatry.

Dr. B. I. Krehbiel has returned to Topeka after spending more than three and a half years in the Navy and will resume his practice in pediatrics. For the past year, as Captain Krehbiel, he served at the Great Lakes Naval Training School, and before that time had spent a year in the Pacific theater.

Dr. Vervil J. Elson, who practiced in Danbury, Iowa, before the war, has opened an office for general practice in Paola. Dr. Elson has been in the Army for the past four years, having served 17 months in Alaska and 15 months in the C. B. I. theater. He is a graduate of the University of Kansas School of Medicine.

Dr. O. W. Davidson, Kansas City, was elected president

of the south central section of the American Urological association at a meeting held in Kansas City in November. This section of the association, now in its 25th year, is made up of members from nine states and from Mexico.

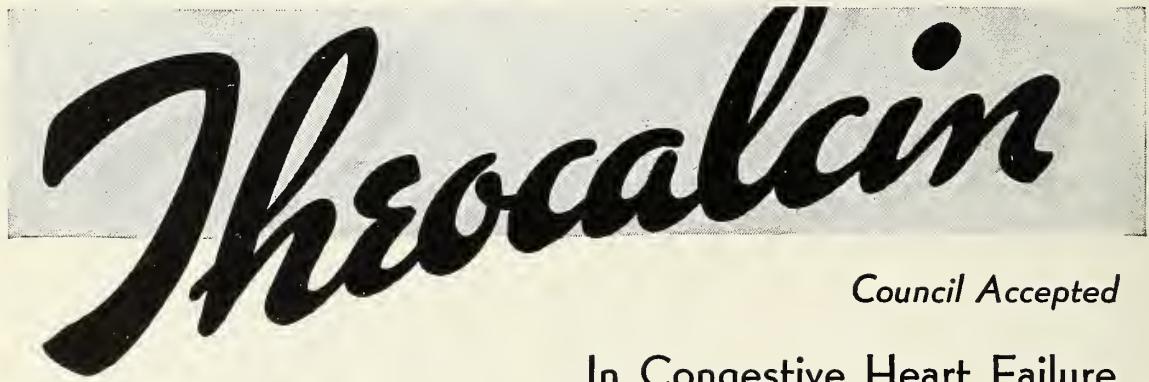
Dr. William B. Scimeca, who has been practicing in Caney for the past year, opened an office in Moline last month. A graduate of the University of Kansas School of Medicine, Dr. Scimeca served his internship at Medical Center and Margaret Hague Maternity hospitals in Jersey City, N. J.

Lt. H. F. Spencer, Garnett, is now head of the anesthesia department of a Navy hospital at Pearl Harbor.

Dr. M. E. Pusitz, who was recently released from the Army, has announced the reopening of his office in Topeka. While in the Army he served as chief of the orthopedic and physiotherapy sections at Hammond General hospital, Modesto, California, and as chief of the same sections at the regional hospital at Camp Haan, California. At the time he was released from the service he held the rank of lieutenant colonel.

Dr. C. M. Fitzpatrick, Salina, has been named Saline county health officer, replacing Dr. George Seitz.

Dr. H. S. Blake has returned to his surgical practice in Topeka after having served in the Navy since March 1942. During the war Dr. Blake was in the Pacific theater with the 2nd Marine division, and for the past two years has been stationed in Washington, D. C. At the time of his release from service he held the rank of lieutenant commander.



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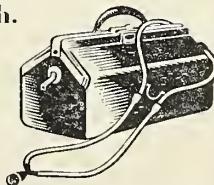
Guns are silent and grass grows in the foxholes, but there can be no peace treaty in the endless war on mankind's immortal enemy—Disease. Home comes the physician from his lifesaving on the battlefields of man-made death abroad to march again beside his colleagues who have so valiantly held the casemates of health at home.

Battle front and home front, boulevard and dirt road, the mighty facilities of the medical center and the challenge of practice in the lonely farmhouse—all are the front line trenches in humanity's continuing crusade to tame cannibal protoplasm. There is no discharge in that war.

The first cry of pain in the world was the first call for a physician. It has been answered as it echoed down the centuries; it will be answered in the unrolling years of the future.

As this questioning year of 1946 opens with the world convalescing from malignant political disease, we would like to claim the privilege of welcoming the thousands of physicians returning from unparalleled service on war fronts—of saluting those who shouldered such heavy burdens at home—of expressing the confidence that the traditional unity of the profession armed with new and potent weapons will drive the front lines of the war on disease ever forward.

We know that we are joined in this expression by all organizations which seek to play their roles, large and humble, as institutions of supply to those "bound by the covenant and oath, according to the law of medicine." S. H. CAMP AND COMPANY, Jackson, Mich.



## KANSAS MEDICAL ASSISTANTS' SOCIETY

### Helping the Doctor Collect His Money\* Part IV

By David Morantz, Kansas City, Kansas

If physicians would analyze their losses on bad accounts, as do many credit men, they would find that the greatest "leak in the bucket of income" is the patient who has moved owing him for services and cannot be located.

In my 32 years experience as a professional collector of professional accounts, I have been astonished at the small amount of information the average physician takes from his patient. Sometimes he has only the last name and that is often spelled incorrectly, so when his statement is returned he is handicapped from the very beginning in his efforts to locate the debtor who moves.

So my first tip to the physician is to get as much information as possible from the new patient.

Try to get the first and middle name, but get full initials always. If you hear the man refer to his wife as Rose, write that down because the wife's name often plays an important part in locating a debtor who has skipped.

The physician can easily ask for the patient's age during his examination and he should be careful to record it because that is another important factor in identifying a skip. Especially is this true where you have located John Russell, Senior, and it is John Russell, Junior, who owes the bill. The age noted on the records will show whether this is a young or an elderly man.

Ascertain the type of work your patient does and the name of his employer, if possible, and be sure to indicate

\*From an address delivered before the Wyandotte County Medical Assistants' Society.

on your records whether your patient is Mr., Miss, Mrs., Jr. or Sr.

If he or she gives you a check, indicate on your records the name of that bank and exactly the style of signature. You may have your patient's name as H. E. Jones, but he may sign his checks Henry Edward Jones and should you ever have to ask that bank to help you locate him or should you ever find it necessary to garnishee his bank account for an unpaid balance, it is highly important that you know exactly how he signed his checks and how his name appears on the bank's records.

You might, and probably do, ask if he has ever had his teeth x-rayed. This offers a fine opportunity to say "By the way, who did the work?" You should make a note of the dentist's name also as he may at some future date be able to help you locate that patient should he move without paying your bill.

If your patient has any special identification marks such as a conspicuous scar, or if he is decidedly blond, brunette, very short or tall or fat or short or thin, jot it down. That little bit of information may mean many dollars to you in identifying your debtor should he become a skip.

If you will keep these few tips in mind and follow them, they will repay you richly in cutting down your bad debt losses from the debtor who moves.

(TO BE CONTINUED)

### Medical Assistants' Annual Meeting

The annual meeting of the Kansas Medical Assistants' Society will be held in Wichita on Sunday and Monday, April 21 and 22. The complete program for the two-day convention will be announced later. At the time of the meeting the proposed changes in the constitution and by-laws will be presented to the membership for approval or rejection.



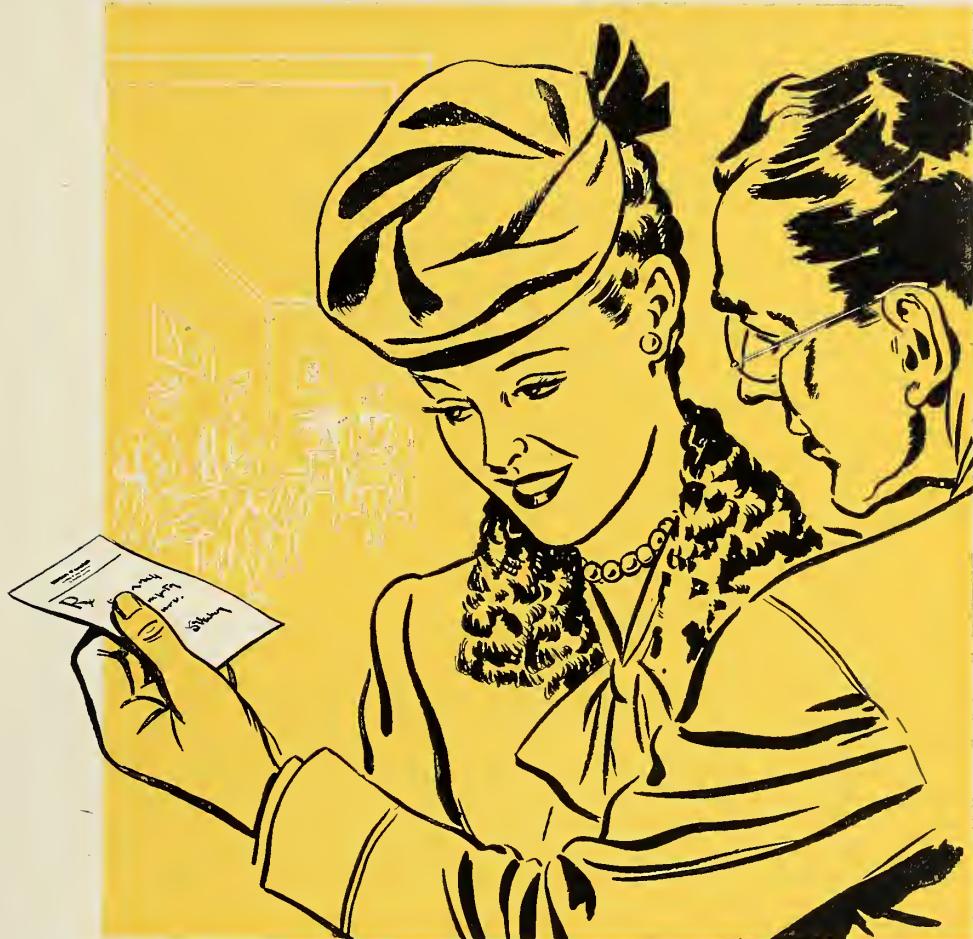
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## AUXILIARY

### President's Message

May the New Year hold everything that is good and fruitful for you is our wish. And for service you have an assignment of real merit. In the history of the American Medical Association there have been only two times that the assistance of the Woman's Auxiliary has been sought specifically by the members of the Association. The first was in the circulation of Hygeia, which has been well done. And now comes a request of vital importance to the medical profession and all who are related to it.

With the great number of our medical men who were taken into service during the war, a great shortage of doctors was necessitated at home. Of course this doubled and redoubled the burden of trying to give medical care to the public. The minds of the doctors have been so filled with concern for their patients that the welfare of the profession has remained a secondary consideration.

At the conference in Chicago December 13 and 14 we were told by those who are concerned that it will be the

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responsibility of the wives of the doctors to defeat the proposed legislation which will destroy the practice of medicine by worthy men. There will be no incentive for a brilliant, energetic, and scientific-minded young man or woman to spend years of preparation and thousands of dollars to practice medicine under the proposed plan.

At the House of Delegates of the A.M.A. the following resolution was passed:

"Whereas, The object of the Woman's Auxiliary is to aid the American Medical Association in every way requested; and

"Whereas, The most urgent need at present is for widespread dissemination of knowledge concerning the hazards of current medical legislation; therefore, be it

"Resolved, That the House of Delegates of the American Medical Association requests the Woman's Auxiliary to use every avenue possible to bring such information to its members and through them to the public."

There is a challenge! Let us meet it and with every effort possible succeed. Here is an opportunity for the program and public relations chairmen to work together, accomplish much public education on the subject. It is an honor to receive this request from the A.M.A., and please may we all take advantage of it by leaving no stone unturned in the success of this effort.

Sincerely,

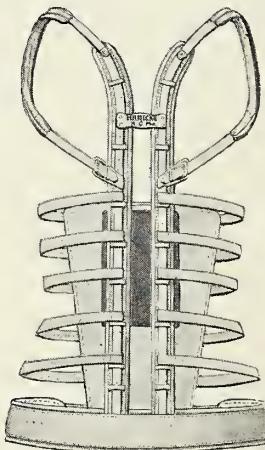
Mrs. Hugh A. Hope

### Archives and History

The Archives and History of the state medical Auxiliary become very interesting after one has come to know almost every member of the various auxiliaries over the state. This year a new file will be purchased and each county will have a section of its own. The state will have a section

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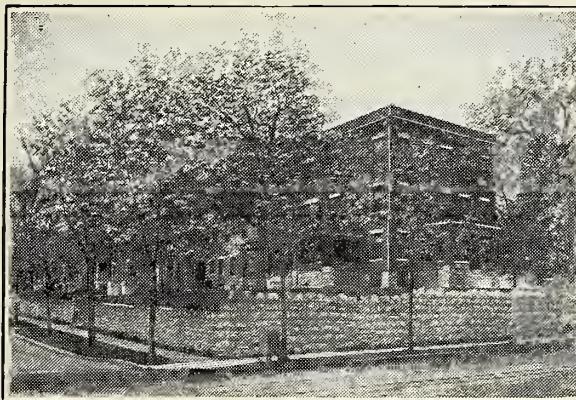
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for each year. The key will be left with the secretary of the state medical building, and any member of the Auxiliary who desires to refer to the files may register and obtain the key.

Suggestions for the year have been sent to the county historians. I am sure they will not find the annual report too difficult.

Reference should again be made to the article on Archives and History which appeared in the Journal of the Kansas Medical Society in November 1944. No changes have been made since that date.

Mrs. C. D. Blake, Chairman.



## Meetings Over the State

The November meeting of the Labette county group was held on the 28th at the county health center with Mrs. O. E. Stevenson as hostess. Mrs. N. C. Morrow, president, conducted the business meeting. The evening was spent in making surgical dressings for cancer patients of the county.

Mrs. Hugh A. Hope of Hunter, state president, was a guest of the Shawnee County Auxiliary at a meeting held December 3 at the home of Mrs. W. F. Bowers, Topeka. Assisting were Mesdames Seth A. Hammel, R. P. Knight, Dale Dickson, H. H. Wood, and W. J. Walker. Mrs. Hope addressed the group on the work being done by the state Auxiliary.

Forty members of the Wyandotte county unit enjoyed a Christmas tea December 14 at the home of Mrs. John H. Luke. Mrs. John A. Billingsley was chairman for the meeting and was assisted by Mesdames Galen Tice, W. J. Feehan, J. G. Evans, Fred Mills, D. N. Medearis, H. H. Hesser, L. B. Spake, L. G. Adams, E. D. Williams, Ray B. Riley, C. A. Gripkey, Harold V. Holter, Ward Summerville, Francis J. Nash, and Robert T. Lucas. Mrs. Medearis and Mrs. Holter presided at the tea table.

As a Christmas activity members brought toys which were distributed among patients in pediatric wards of the city, and the group gave ten dollars to the tuberculosis fund. Musical numbers and a short skit were presented by the Wyanotte radio broadcasting club and boys' quartet.

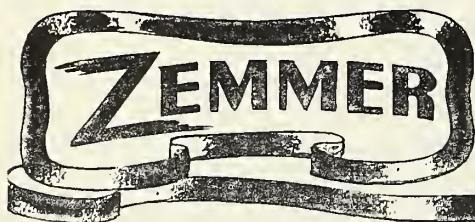
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Volume XLVII

FEBRUARY, 1946

Number 2

**PRIMARY CARCINOMA OF THE ILEUM (Case Report)**

Jack M. Leopard, M.D.

Kansas City, Kansas

Primary carcinoma of the small intestine comprises a small percentage of the neoplasms of the gastro-intestinal tract. Ewing<sup>1</sup> states that it forms three per cent of all intestinal cancers. Brill<sup>2</sup> in his collected statistics reports an incidence of 2½ per cent. In an excellent review by Raiford<sup>3</sup> of 986 tumors of the gastro-intestinal tract, 776 were malignant, with 38 occurring in the small intestine or an incidence of 4.9 per cent. Benign tumors are found less frequently in the gastro-intestinal tract although their occurrence in the small intestine is relatively greater. In Raiford's group only 210 were benign, although 50 occurred in the small intestine, giving an incidence of 23.8 per cent.

Carcinoma may occur in any portion of the small intestine while the most frequent sites vary with different investigators. Mayo<sup>4</sup>, in a series of 108 primary malignant tumors of the small intestine of which 80 were adenocarcinoma found 23 in the duodenum, 31 in the jejunum and 21 in the ileum. None of these were located in Meckel's diverticulum, although four leiomyosarcoma were found in this structure. Raiford<sup>3</sup> in 16 cases of primary carcinoma of the small bowel found seven located in the duodenum, four in the jejunum, and three in the ileum. Nickerson and Williams<sup>5</sup> found six carcinoma in the duodenum, two in the jejunum and none in the ileum. Ileum ranks as the least common site by most observers. Origin in Meckel's diverticulum is rarely encountered. Horsley<sup>6</sup> in reviewing the literature between 1932 and 1941 collected a total of 236 cases of adenocarcinoma of the jejunum and ileum, of which seven were found in Meckel's diverticulum. Malignant tumors in this embryological structure are more likely to be of a sarcomatous variety.

Carcinoma is the most common variety of malignancy encountered. It formed 80 per cent of the 108 cases reported by Mayo<sup>4</sup> and of the 10 cases reported by Nickerson and Williams<sup>5</sup> eight were carcinoma. However, only 16 of Raiford's<sup>3</sup> 38 ma-

lignant tumors were carcinoma. Carcinoma of the small intestine may be divided into four main types, adenomatous, medullary, scirrhous and colloid. The first is by far the most common, the second less frequent and the last two rare. They may occur in one of three forms (1) a polyp (single or multiple) which has undergone malignant degeneration (2) an annular constricting lesion, the so-called "napkin ring" type and (3) carcinoid or argentaffine tumor. Carcinoid tumors are most common in the appendix, where they are considered benign, however their occurrence in the small intestine is not uncommon. In a series of 30 carcinoid tumors of the small intestine reported by Dockerty and Ashburn<sup>7</sup>, they formed 26 per cent of the carcinoma of the small intestine encountered during the same period of time. All occurred in the ileum, while several cases included multiple sites in the small intestine. Thirteen of the 26 tumors showed definite local and regional metastases. While they are considered benign in the appendix, carcinoid tumors show definite malignant possibilities in the small intestine.

Several interesting explanations have been offered as to the relative infrequent occurrence of carcinoma in the small intestine. Rankin and Mayo<sup>8</sup> suggest that it may be due to several factors (1) the fluidity and alkalinity of the intestinal contents and (2) the absence of sharp bends in the small intestine. The duodenum is often the site of occurrence, in spite of its relatively short length. Forgue and Chauvin<sup>9</sup> explain this on the basis of the four flexures present, the fixation by the parietal peritoneum, and the fact that the duodenum is the most widely dilated portion which predisposes to stasis of the intestinal contents.

Symptoms are somewhat variable but usually exhibit two main features (1) increasingly severe recurrent attacks of intestinal obstruction with complete relief between attacks and (2) anemia, weakness and fatigability. The patient may show melena, constipation or weight loss. Diagnosis is usually not made preoperatively, but more often at

\* From the Department of Pathology, University of Kansas School of Medicine.

the time of operation. Mayo<sup>4</sup> states that correct preoperative diagnosis was made in only 25.7 per cent of his cases. Roentgen examination is becoming more helpful, and may give the only clue preoperatively. One is hesitant in feeding barium to a patient with an intestinal obstruction, but with a Miller Abbott suction tube in place, and with a fine solution of barium a filling defect may be seen at the site of the constricting tumor with dilation of the bowel proximal to it. Metastases occur early which Mayo<sup>4</sup> explains as due to the rich absorptive field which the small intestine possesses and because of its abundant blood supply and lymph drainage. Metastases occur in order of frequency to the lymph nodes of the mesentery, peritoneum, liver, lungs, long bones and dura mater.

#### CASE SUMMARY

M. B., 61-year-old white female, was admitted to University of Kansas Hospitals on May 10, 1944 with a three months' history of recurring attacks of abdominal distension, cramps, nausea and vomiting. The initial attacks were of a mild nature, occurring at weekly intervals and lasting only a few hours, but then gradually increased in severity and frequency until they became constant 10 days before admission. Complete relief was present between attacks, and no change in bowel movements or tarry stools were noted. A weight loss of 25 pounds had occurred in the preceding two months. Coffee ground vomitus was seen twice. The patient had been a diabetic for 15 years and was adequately controlled on 20 units of protamine zinc insulin daily. Physical examination showed generalized abdominal enlargement with tenderness, palpable peristaltic waves and numerous borborygmi. Laboratory findings were essentially negative except for a mild anemia with a red blood cell count of 3,920,000, hemoglobin 76 per cent and a trace of both albumin and sugar present in the urine. The blood sugar was 96 mg. per cent, total blood protein 3.78 per cent and albumin globulin ratio of 2.67/1.11. Roentgen examination of the abdomen showed coils of dilated gut filling the mid-abdomen. The distance between the coils of gut was thought to be greater than seen normally indicating a thickened peritoneum or exudate over the peritoneal surface. Barium enema failed to reveal any abnormality. Conclusion

was that of a small gut obstruction, with peritonitis seriously considered. On June 12 laparotomy was performed through a lower right rectus incision under spinal anaesthesia. At about the mid-portion of the ileum was found a constricting tumor measuring approximately 4 x 5 centimeters in size. Proximal to this obstruction the bowel was several times enlarged, with a much thickened wall, and dilated lumen. About 2½ feet of bowel with tumor was removed, the bowel sutured together by the modified Mikulicz technique, and the wound closed carefully. The gross pathological examination revealed an annular indurated tumor producing definite constriction of the lumen, with ulceration, and metastases to regional mesenteric lymph nodes. The bowel proximal to the tumor showed dilation with hypertrophy and thickening of the wall. Microscopic examination showed epithelial proliferation suggesting branching glandular structures with invasion into the underlying muscle and stroma, and showing rather striking variation in size, shape and staining of the cells with distinct tendency to acinar formation and some secondary inflammatory reaction. Some areas showed a tendency to mucoid degeneration. The epithelium was suggestive of gastric mucosa rather than intestinal, and it was considered that this tumor may have originated in a Meckel's diverticulum. Regional mesenteric lymph nodes showed partial replacement by tumor tissue. Post operatively the proximal loop of gut became necrotic and on the 13th postoperative day the patient showed definite evidence of peritonitis with death occurring five days later. At autopsy both segments of the ileal loop showed necrosis and gangrene, associated with an acute fibrinopurulent peritonitis and multiple foci of suppuration. Death resulted from the slough of the ileostomy with resulting peritonitis. No tumor was found in the ab-



Fig 1 Carcinoma of Small Intestine



Fig 2: Micro-photograph of Tumor Mag X-125

domen, or microscopically in the lymph nodes removed at time of autopsy.

#### CONCLUSION

Primary carcinoma of the small intestine is a rare entity, and is still more rarely recognized preoperatively. This patient underwent removal of the primary tumor and regional lymph nodes several of which showed metastases. No metastases, gross or microscopic, were found in the autopsy material, therefore this patient may have represented a cure had not the immediate postoperative death occurred. However, it is possible that metastases may have existed in regions that were not examined, or may have been of microscopic size.

It is unlikely that this tumor originated in a Meckel's diverticulum, because the typical blind

sac was not found. However, the similarity of the microscopic picture to that of gastric mucosa suggests its origin from aberrant gastric mucosa.

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## SUBMUCOUS LIPOMA OF THE JEJUNUM: REPORT OF A CASE

John William Cavanaugh, M.D.  
Fort Dodge, Iowa

and  
William Merrill Mills, M.D.  
Topeka, Kansas

Benign neoplasms of the small intestine are uncommon. According to operative records at the Mayo Clinic<sup>2</sup> their frequency is about one-half that of carcinoma. At necropsy, however, they have been observed twice as frequently as carcinoma<sup>3</sup>.

The most common of the benign neoplasms are adenomas and myomas which occur with equal frequency and comprise two-thirds of these neoplasms. The others, fibromas, lipomas, hemangiomas, lymphangiomas, and osteochondromas are less commonly reported, in approximately the order named. Herein, a submucous lipoma in the upper jejunum causing intestinal obstruction, is reported.

#### REPORT OF CASE

G., a 55-year-old white woman, was admitted to St. Francis Hospital, Topeka, Kansas, September 26, 1943. She complained of cramping pains about the navel and persistent vomiting for six days. The onset

of abdominal pain eleven days prior to admission was sudden and occurred while eating lunch. Nausea and vomiting were not present at that time. The pain gradually subsided within a few hours, although abdominal soreness persisted. For the next five days her appetite continued good and her bowels moved daily. No abnormalities of the stools were noted. Six days prior to admission, the cramping pain returned and vomiting of all ingested food and water began. Marked anorexia accompanied the persistent vomiting. She had had no bowel movements for several days when admitted.

The past history and family history were irrelevant.

On physical examination she was well developed and well nourished, and quite dehydrated. Temper-



Figure 1. Specimen removed.

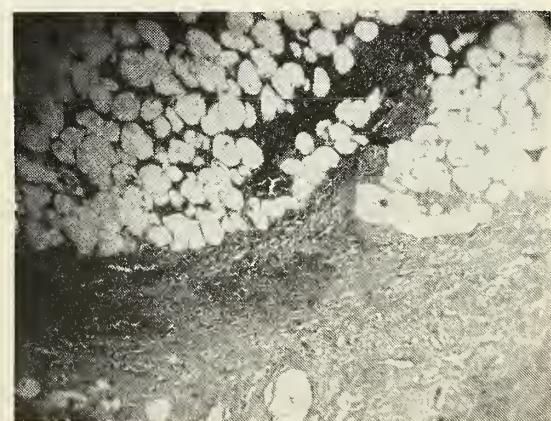


Figure 2. Microphotograph.

ature 98.6° F., pulse rate 100. She weighed 140 pounds. The pupils reacted to light and accommodation; no icterus was noted in the sclerae. The teeth were in good repair, the tongue dry and coated. The lungs were clear to percussion and auscultation. The heart was not enlarged, the rhythm was regular and no murmurs were heard. The blood pressure was 120/80. The abdomen was not distended. No operative scars were noted. There was slight tenderness about the navel. There was no rigidity and no masses were palpated. Peristaltic sounds were heard. There were no herniae. Pelvic and rectal examinations were essentially negative. Deep tendon reflexes were present and equal.

Urine analysis was entirely negative. Red blood cell count was 4,000,000 per cubic millimeter, white blood cell count was 8,000 per cubic millimeter, with 81 per cent neutrophils and 29 per cent lymphocytes. The blood Kahn test was negative.

On the evening of admission the patient vomited several times and the intestinal colic persisted. Wangensteen suction was instituted and intravenous fluids were administered. The patient improved markedly and her symptoms subsided. Her bowels moved on the second hospital day. Suction was temporarily discontinued and pain and vomiting recurred within 12 hours. Suction was re-instituted and a small amount of barium was given by mouth. This revealed the esophagus and stomach to be normal and distention of the first portion of the jejunum. After 24 hours no barium had passed the upper jejunum.

Laparotomy on 10-1-43, disclosed a moderate dilation and hypertrophy of the muscular coats of the upper jejunum. About 18 inches past the duodenjejunal junction a mass which completely obstructed the bowel was palpable within the lumen of the jejunum. Distal to this point the small bowel was collapsed. A dimpling of the antimesenteric surface of the jejunal wall was noted at the apparent attachment of the mass. There was beginning intussusception without actual inversion which apparently was prevented by the firmness and thickness of the muscular wall and the large caliber of the lumen. Upon opening the bowel a globular mass 8 x 3 cm., was attached to the mucosa by a pedicle one cm. in diameter. A necrotic debris covered the ulcerated surface of the growth. The mass, with the pedicle, was excised and the bowel closed.

There are four criteria for diagnosis of virus infection or atypical pneumonia, namely, the history, the clinical picture, laboratory picture, and x-ray picture. Any three of these criteria seem sufficient, bearing in mind that the x-ray examination is confirmatory but not always diagnostic.

Complications are not infrequent. Pericarditis and myocarditis by extension do occur and may be fatal if not dis-

The postoperative course was uneventful except for a small abscess in the operative wound which was drained on the eighth postoperative day.

The specimen removed consisted of a pear-shaped mass of tissue measuring three cm. at the bulbous end, one cm. at the stalk, and was eight cms. long. The surface, except at the base, was discolored, red and brown gray. On the cut surfaces, the discoloration extended to a depth of about 0.5 cm. and then faded gradually into pale yellow adipose tissue.

Microscopic examination of a portion from near the pedicle revealed the surface to be covered by a necrotic debris with some ghost outlines of intestinal mucosa with occasional remains of the muscular mucosae. Beneath this were adipose tissue cells forming various sized lobules. Between these were broad bands of fibrous connective tissue containing blood vessels. The latter were markedly distended with blood and there was massive extravasation of blood between the adipose tissue cells. Near the surface and elsewhere, nuclear staining was lacking, the tissue elements were spread apart and there were dense infiltrations of polymorphonuclear granulocytes and red blood cells. Thrombi filled the lumina of some of the blood vessels.

#### COMMENT

Submucous lipomas of the gastro-intestinal tract were reviewed by Comfort<sup>1</sup> in 1931, who found 181 cases reported up to that date including the cases collected by Stettin in 1909. Among these, eleven were "definitely" in the jejunum. Only two of these produced clinical symptoms.

According to a more recent review by Schottenfeld<sup>4</sup>, 275 cases of submucous lipoma have been reported up to 1942. Among these several cases were cited in which pedunculated growths sloughed from their attachments and were passed in the stools. Schottenfeld gives a complete discussion of the theories of genesis, the symptomatology, and complications of these tumors. An exact diagnosis is seldom made before operation.

As in our case, the symptoms of submucous lipoma of the small bowel are those of intestinal colic and the chief dangers are intussusception or obstruction by obturation.

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covered reasonably early. Psychic disturbances are a very real problem in this disease.

Prolonged rest in bed, later restricted activity, are the only successful methods of therapy in our experience. Many patients who reach chronicity without treatment carry the toxic manifestations for months or even one to three years.—Grover C. Dale, M.D., in *Southern Medicine and Surgery*, May, 1945.

# POSTOPERATIVE BACTERIAL SYNERGISTIC GANGRENE CURED WITH PENICILLIN\*

Vincent G. Cedarblade, M.D.  
Denver, Colorado

and  
Thomas G. Orr, M.D.  
Kansas City, Kansas

The following two cases of postoperative gangrene of the type described by Meleney<sup>1</sup> were successfully treated with penicillin given intramuscularly and applied locally. This type of infectious gangrene usually follows drainage operations upon the thorax or abdomen. It is characterized by a progressive destruction of the skin and subcutaneous tissues which, in the past, has been treated by complete cautery excision beyond the advancing margin of the ulceration. Cultures made from the raised dusky purple swollen margins of such infections have shown a microaerophilic non-hemolytic streptococcus and hemolytic staphylococcus aureus. The synergistic action of these two organisms is believed to cause a type of progressive gangrene of the skin and subcutaneous tissues which is now considered a definite clinical entity.

Case 1. A man, aged 53, was operated upon November 29, 1944, for a lung abscess. Sulfadiazine was given for 48 hours after operation but was discontinued because of nausea and vomiting. Five days after operation a rapidly spreading ulceration was noted about the chest wound (Fig. 1). Cultures from the ulcerated area showed a staphylococcus aureus and from the ulcer margin a microaerophilic streptococcus. Eight days after operation the ulcerated area measured 7 x 10 cm. Sulfadiazine was again given without success. Sulfadiazine combined with zinc peroxide applied locally did not check the progress of the ulceration.

On the 13th postoperative day treatment with penicillin was begun. Intramuscular injections of

From the Department of Surgery, University of Kansas Hospitals, Kansas City, Kansas.

12,500 units were given every three hours and a paste, made of zinc peroxide and penicillin (250 units per cc of water), was applied to the ulcerated area three times daily. In the first 24 hours 100,000 units were given in the muscle. Penicillin was then continued intramuscularly in doses of 10,000 units every three hours for four days. During this time 320,000 units were given. During the next eight days 320,000 units were given intramuscularly. Local application of penicillin and zinc peroxide was continued over the entire period of treatment. A total of 740,000 units of penicillin was injected intramuscularly.

Improvement was noted in the ulceration in six days. The progress of the gangrene had stopped and the margin of the ulcer was growing pink. After two weeks all evidence of ulceration had disappeared leaving a clean granulating area which healed normally.

Case 2. On November 15, 1944, a man, aged 35, had an appendectomy with drainage of a long standing appendiceal abscess. Drainage was profuse for several days. At the end of two weeks ulceration of a portion of the wound margin was noted. The margin of the ulceration was elevated, somewhat undermined and had a dusky purple color (Fig. 2). Treatment with zinc peroxide was tried for three days without improvement. The ulcer measured 4 x 5 cm. Penicillin in doses of 12,500 units injected intramuscularly was given every three hours for twenty-four hours. Then for four days 10,000 units were given every four hours. During the next three days this was reduced to 10,000 units



Fig. 1. Infectious gangrene of skin following drainage of lung abscess.



Fig. 2. Infectious gangrene of skin following drainage of appendiceal abscess.

three times daily. A total of 510,000 units was injected intramuscularly.

During the entire treatment by intramuscular injection, local application of 250 units of penicillin in zinc peroxide paste was used three times daily.

After 48 hours treatment with penicillin, the ulcer showed improvement. In five days the progress of the ulceration had ceased, and clean granulations appeared. Healing then progressed normally.

#### COMMENT

These two cases of postoperative progressive

synergistic gangrene responded promptly to penicillin treatment. From Case 1 the organisms isolated corresponded to those described by Meleney. In the second case the typical organisms were not isolated. The clinical picture in both cases was characteristic of progressive synergistic bacterial gangrene of the skin and subcutaneous tissues.

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## CHEMOTHERAPY IN TUBERCULOSIS

Efforts to develop an effective medicinal treatment for tuberculosis have undoubtedly been under way ever since this great human pestilence was recognized. The writings of ancient physicians contain repeated reference to herbs and other natural products alleged to be of therapeutic value. When Ehrlich and his contemporaries learned of the value of metallic salts in treating syphilis and parasitic diseases, hope was revived that some such preparation might be of aid in treating tuberculosis. The use of gold salts in the treatment of tuberculosis appears to have been an outgrowth of this line of research, but treatment with these has not withstood the test of time.

The unprecedented success of the sulfa drugs in treatment of many bacterial diseases of man renewed hope that tuberculosis might eventually yield to some such drug, and experiments on guinea pigs have given definite support to these hopes.

In 1939 and 1940 the sulfonamide drugs were shown to have some retarding effect on the rate of development of tuberculosis of guinea pigs, but in no instance did the drugs actually arrest the disease.

The drugs of the sulfone series (promin, diasone and promizole) were the first preparations to succeed in actually arresting tuberculosis in the highly susceptible guinea pig. This led to high hopes that sulfone drugs might be of value in the treatment of human tuberculosis. Several hundred tuberculosis patients have now received treatment with these drugs. Experience has tempered the early enthusiastic hopes of some physicians.

Most sulfone drugs, unfortunately, have a much more toxic effect on human beings than on guinea pigs. It is suspected that some sulfone drugs are altered in the human body and become ineffective. The possibility that sulfone drugs may be of aid in treatment of certain unusual varieties of human tuberculosis has not been excluded, but no definite place has been found for these drugs in treatment of the usual types of tuberculosis. The use of sul-

fone drugs under any circumstances has not progressed beyond the experimental stage.

The only sulfone drug which has been approved by the Federal Drugs Administration for sale is promin. This is available in jelly form for application on the surface of external tuberculosis lesions. The effectiveness of promin has not been competely established even for this special use.

The amazing success of penicillin in treatment of several infectious diseases again aroused hopes that this or a similar antibiotic substance might be developed which would be effective against tuberculosis. Penicillin itself appears to have no effect on tuberculosis in guinea pigs or in man, but many other substances may be extracted from living micro-organisms which can suppress the growth of bacteria which produce disease.

Of these only streptothricin and streptomycin need now be considered. Streptothricin and streptomycin are both derived from soil-inhabiting fungi (*Actinomyces lavendulae* and *Actinomyces griseus*). Both restrain the growth of tubercle bacilli in the test tube. Streptothricin is somewhat toxic to guinea pigs and does not restrain the development of tuberculosis in these animals.

Streptomycin is well tolerated by guinea pigs, and extensive investigation has shown that it does inhibit in them the growth of experimental tuberculosis. In a third of the guinea pigs treated streptomycin apparently will eradicate advanced tuberculosis. In the other two thirds treatment with streptomycin will bring the disease to a stage that can be regarded as arrested.

Adequate study of streptomycin in treatment of human tuberculosis remains to be done. Certain obstacles lie in the path of further progress along this line.

Many students of tuberculosis believe that results comparable to those noted in acute diseases, such as pneumonia, should not be anticipated in drug therapy of as generally chronic a condition as tuberculosis. In any disease successful treatment

with drugs merely permits recovery by natural processes, and the promptness of such recovery depends on the nature of the disease process and the defensive powers of the patient.

Tuberculosis, however, by virtue of its usual chronicity produces destructive changes in tissues. Healing or repair of these tissues is exceedingly slow. Furthermore, in extensive tuberculosis of the lungs the destructive changes offer serious mechanical handicaps to healing. When such mechanical handicaps exist a corrective mechanical type of treatment, such as the conventional surgical collapse procedures, is used rather than treatment with a drug. The physician therefore does not hope for any alternative chemical remedy when surgery is indicated. Rest therapy, usually in the planned environment of a sanatorium, will probably remain the fundamental remedy for tuberculosis. No drug now available is likely to supplant rest completely. At this time it would appear foolish to discard the known benefits of rest treatment for the uncertainties of treatment with a new drug.

Patients are frequently eager to receive newly developed drugs even when the hope of benefit is remote. Usually it is impossible to secure such drugs under these circumstances due to present-day legal restrictions designed to prevent unwise distribution of drugs whose safety and efficacy have not been determined.

The distribution of new drugs for the necessary preliminary, laboratory and clinical trials is entirely in the hands of the manufacturers. Investigators receiving drugs for this purpose must have proper facilities to carry out the contemplated research

accurately and safely. They also may be called on to account for all of the drug supplied and to submit complete reports of their researches which eventually are forwarded to the Federal Security Agency. Obviously, it is impossible for research workers to share their supplies of new drugs before the necessary research is completed.

The channels through which information about new scientific developments flows are direct and dependable. When a research worker has completed a project, he submits a report to the editors of one of the many medical and scientific journals, and usually publication of the results of his work follows within a few months. This enables other research workers and physicians to utilize promptly any of these new facts either in treatment of patients or in the development of new scientific information. The prompt publication of results is an ethical responsibility of the scientist to aid others engaged in similar problems. No one need fear that he will be denied any valuable secret remedy.

Newspaper reporters and authors of magazine articles recognize the news value of scientific discoveries. Occasionally they use sources of information less authoritative than those of established medical journals, to the chagrin of research workers and to the confusion of patients. Human lives may be lost needlessly if patients who have tuberculosis choose to forsake or refuse well-established methods of treatment in the hope of receiving remedies inadequately tried or of unproved effectiveness.

*Chemotherapy in Tuberculosis, H. C. Hinshaw, M.D., and William H. Feldman, D.V.M., The NTA Bulletin, Oct. 1945.*

### American College of Physicians Meeting

The American College of Physicians has announced that its schedule of annual meetings will be resumed in 1946. Philadelphia has been chosen for the 1946 meeting, May 13 to 17, inclusive, with headquarters at the Philadelphia municipal auditorium, 34th street below Spruce. Dr. Ernest E. Irons, Chicago, will preside with Dr. George Morris Piersol, Philadelphia, as general chairman.

### Program for Regular Army Doctors

Under the new program designed to give professional training to doctors in the regular Army, 100 medical officers have been assigned to Army General Hospitals and medical installations. The plan assures a professional career to doctors in the regular Army, and provides for graduate training and aid in obtaining board certification for medical specialties from recognized civilian specialty boards.

### Directory of Surgical Training Plans

The American College of Surgeons has published a 424-page directory in which are listed and described the approved programs of graduate training in surgery in 240 civilian hospitals in the United States and Canada, and in 42 naval, seven Veterans' Administration, and 10 U. S.

Public Health service hospitals. The material was compiled chiefly as an aid to medical officers returning from war duty.

### Clinical Conference in March

The Chicago Medical Society has announced plans for a clinical conference to be held at the Palmer House, Chicago, March 5-8. The conference last year was cancelled because of government restrictions on travel.

### Board Announces Examinations

The American Board of Ophthalmology has announced that the examination originally scheduled for Los Angeles, January 28 to 31, has been changed to San Francisco, June 22 to 25, inclusive. Other 1946 examinations will be held in New York, April 10 through 13, and in Chicago, October 9 through 12.

### Refresher Course at St. Louis

St. Louis University has announced completion of the curriculum for refresher courses for physicians from March 15 to June 15, 1946. The entire facilities of the school are thrown into these courses and in each instance one full semester's work will be covered. Courses will be offered in internal medicine, surgery and the specialties.

## PRESIDENT'S PAGE

TO THE MEMBERS OF THE KANSAS MEDICAL SOCIETY:

As we stated in our previous President's Page, the first post-war meeting of the Kansas Medical Society will be held in Wichita on April 21 to 24, 1946. We are urging you at this time to make every effort to help promote the success of this meeting and you may do this by contributing to the scientific exhibits and attending as many of the scientific programs as possible.

The work of the Kansas Physicians Service is progressing. Twenty-five states are now participating in this type of service and many others are making similar plans. The Council of the American Medical Association, with the aid of its Advisory Committee on Prepayment Medical Care Plans, has prepared a report on the coordination of the various state plans. This will be discussed at a meeting of the entire Board of Trustees and the Council. In addition, on February 10 a national conference on medical service will be held in an attempt to establish a national insurance program. We hope this can be correlated with the Kansas Physicians Service. If every member of all the state societies participated in a physicians' service plan, there would be no reason why socialization of medicine should even be considered by the government.

The response to the Veterans Administration program has been very satisfactory. The committee approving the classification of the various physicians will meet soon and will not be able to include the name of any physician who has not signed up by February 25, 1946. If you wish to participate in this plan and have not already signed up, kindly do so before that date.



President

## EDITORIALS

### President-elect of the AMA

Dr. Harrison H. Shoulders, Nashville, Tennessee, for many years speaker of the House of Delegates, was named president-elect of the American Medical Association at the December, 1945, meeting of the House of Delegates in Chicago.

In Tennessee, where Dr. Shoulders is best known, the press was generous in reporting his election and in reviewing his service to the medical profession, as secretary of the state medical association, as editor of its journal, and as spokesman in the fight for the freedom of medicine from political encumbrance. The following paragraphs are from an editorial which appeared in the Nashville Banner at the time Dr. Shoulders was elected to the national office.

"Dr. Shoulders will take office next year, but the fact doesn't abate the force of his immediate fight, and the American Medical Association's. They have mobilized for it; obviously are recruiting leadership of maximum stature, and command thereby the faith of the American public whose welfare is at stake. It is hardly likely that thinking American citizens will prefer political voices to authoritative, medical voices on a subject involving life and health. It is inconceivable that thinking citizens will permit subjection of MEDICINE to the principles of boondoggling, or assign it to the arrogant, untender mercies of bureaucracy . . .

"The American Medical Association is to be congratulated for choice of such a leader; Dr. Shoulders for the opportunity conferred; the country for possession of such leaders for the defense of principle at home."

### State Controlled Medicine in New Zealand

Quentin Pope, newspaper man in New Zealand, wrote for the Chicago Daily Tribune of November 29, 1945, on the increasing costs of state medicine in New Zealand. He said, "In six years of operation New Zealand's system of state medical care has ballooned costs, jammed hospitals, promoted a physicians' racket of large dimensions, and speeded the development of a nation of nostrum takers. The system has not cut sickness and has not provided adequate medical service."

According to his analysis hospitals are jammed with the aged and chronically ill, leaving no room for patients with acute disturbances. Under criticism also is the medical profession which has disclosed that there are ways of increasing income and

is no longer giving its best efforts. Some doctors see patients at a rate exceeding 15 an hour and send all really ill persons to a hospital where hospital attendants are responsible for their care. Other instances are on file where doctors visit state institutions and have inmates sign cards entitling the physician to payment from the government. In this way thousands of dollars are received for very little time and effort spent. He cites instances of collusion with druggists whereby physicians leave a stack of signed prescription blanks with the druggist, who fills them as patients come by.

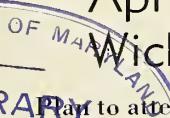
If the reporter from New Zealand is correct, the government is familiar with these abuses but is not attempting to correct them because income taxes stand at 77½ per cent, so the government gets back most of the money anyway!

The medical society of New Zealand defends itself by saying that abuses such as those named are practiced by foreigners who have drifted into the country, but recognizes that these activities give the entire program a bad reputation. The Minister of Health is said to have seriously considered disbanding the program. According to a press release, the administration is already negotiating with the National Medical association to work out a different system.

Costs have risen alarmingly from four per cent of the annual income to nearly 12 per cent at present. It is expected to rise still higher as people become accustomed to taking advantage of something that is paid for.

In the United States the New Zealand system of compulsory sickness insurance is frequently mentioned as an ideal situation. Whether or not the above comments are based on reality is less important than the fact that persons in that nation are voicing their disapproval of the system. Before the government of the United States proceeds to copy the New Zealand program, it might save this nation many unpleasant and expensive experiences if that system which has been in force more than six years would be carefully analyzed by a thoughtful and unprejudiced committee.

**87th Annual Session  
Kansas Medical Society  
April 22-25, 1946  
Wichita, Kansas**



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Call to attend the first post-war session.

## Kansas Leads in X-rays

More than three years have elapsed since the Division of Tuberculosis Control of the State Board of Health made available to the people of the state the 35-millimeter photo fluorographic unit. This mobile unit has been taken to many parts of the state, making chest surveys on a screening basis, and has thereby assisted the medical profession in obtaining clues which frequently have led to earlier diagnosis and treatment than would otherwise have been possible.

This survey has been limited during the war because of equipment and personnel shortages. These are now being eliminated and counties which have not had the opportunity of securing the state-owned and operated photoroentgen units for county-wide surveys may soon obtain them for use. Those medical societies interested in this project are invited to inquire further by writing to the Division of Tuberculosis Control, State Board of Health, Topeka, or to the executive officer of the State Board of Health. Since it has been the policy of this division to survey counties only if invited to do so by the local society, requests from any other source cannot be honored.

Requests for this service are honored in the order received where practicable. Counties with full time health units are given priority, since they alone can offer adequate follow-up services. In all instances, an advance agent of the Tuberculosis Control Division will visit the community to confer with medical society officers, other responsible officials, civic and lay groups and assist in the necessary arrangements, publicity, selection of site and date of the survey, etc.

In the past it has not been possible to comply with the numerous requests received for this mass x-ray service. The addition of three 70 mm. units to those already in operation will shortly make available six P-F units for state-wide x-ray surveys.

Kansas is one of the first states in the union which has x-rayed more than one-tenth of her population. To date, 35 counties have received this service. Kansas confidently expects to increase these activities during 1946.

## Need for Medical Books in Manila

Some months ago the Academy International of Medicine and Dentistry moved its executive office from St. Paul, Minnesota, to the Liberty Life building, Topeka. According to the executive secretary, Mr. J. B. Young, one of the projects of this organization is to attempt to supply the destroyed medical library at the University of Manila with sufficient books to enable the school to operate. It is well known that the Japanese destroyed the university and its library until almost no piece of usable equipment remained.

The Academy International is appealing to the medical profession all over the United States to donate books that may be sent to Manila. Already 10,903 individual publications are in transit and many more are needed. These books have come from individuals, from medical libraries, medical schools and clinics.

Kansas doctors are invited to assist in this worthwhile undertaking through the contribution of books, periodicals or cash. Doctors willing to donate books should first write Mr. J. B. Young, Academy International of Medicine and Dentistry, Suite 101, Liberty Life building, Topeka, giving the names and authors and edition numbers of the books that are available. In an effort to send only material that is critically needed and to avoid duplication, all gifts should be cleared before they are sent. The donor will then be instructed which of these books are desired. If cash is given, the donor may be assured that all money will be used for the purchase of needed books, that arrangements have been made with leading publishers to sell books for this purpose at cost, and that they will be forwarded immediately to the library at Manila.

## Delegates to Annual Meeting

Each county society is entitled to select one delegate for each 20 members in good standing or major fraction thereof. County societies having fewer than 20 members are entitled to one delegate. County secretaries are reminded that those members for whom 1946 dues have not been paid at the time of the annual session, April 22-25, except members in active service, cannot be counted in determining the number of delegates that may vote in the House of Delegates. Membership cards are required for entrance to scientific meetings. Secretaries are also reminded that the names of delegates and alternates elected by each county society should be sent to the Executive Office, 406 Columbian building, Topeka, prior to the opening of the annual session.

By action of the Council early in the war, dues for members actively serving with the armed forces have been suspended for the duration of their active service. Those members have been receiving service memberships without cost, which membership entitles the doctor to all privileges of regular membership. Upon separation from service, dues will again be payable unless the medical officer remains out of practice or out of the state for an entire year. When the returning veteran is in practice for only a portion of a year, dues to the state society are pro-rated according to the number of months he has been engaged in practice.

Now that many medical officers are being separated from service, the Executive Office has been instructed not to mail service memberships to any member unless informed by his county society that the member is still in active service. Unless the Executive Office is informed that the veteran who is at present discharged from the service or on terminal leave will not return to practice for a year, his dues are payable. This information should be forwarded by the secretary of the county society if the member is to be included in tabulation determining the number of delegates to be elected.

The annual session of the Kansas Medical Society will be held in Wichita, April 22-25. The House of Delegates will meet on Monday, April 22, and again on Thursday, April 25. Societies should elect their delegates at their next meeting and notify the Executive Office of their selections.

## EXECUTIVE OFFICE

### Anti-vivisection Battle

In the legislature of the state of New York a battle is raging over vivisection on dogs. A bill has been introduced prohibiting the use of the dog for medical experimentation. The medical profession is fearful of its passage and has distributed a great deal of literature on this subject to all state medical associations, appealing to them for assistance. If the DiConstanzo-Davidson anti-vivisection bill passes, it will immediately react on the profession in the entire United States and will undoubtedly become an influence in many other state legislatures as well as before the federal Congress.

New York is alarmed because proponents of this measure have been gaining strength. Last year a similar bill passed the state Senate by an overwhelming majority and almost succeeded in passage in the lower house. The 1946 bill has received a great deal of preparatory propaganda and has a much better chance of passage. Enrolled in support of the measure are not only anti-vivisection societies but Boy Scout groups, fraternal organizations, women's clubs and schools. In fact more than 119,000 signatures appear on a petition supporting this bill.

The medical society of the state of New York has prepared a pamphlet entitled "Dogs, Drugs and Doctors." This interesting booklet presents the case from the point of view of the medical profession and is briefly reviewed here. Perhaps Kansas will never need to face this issue, but should it be necessary the experience gained in New York will be of value.

"Dogs, Drugs and Doctors" is an appeal to the layman reviewing ways in which dogs have assisted the doctor of medicine. More than 20 abdominal operations, and Harvey Cushing's famous operation on the pituitary gland, were made possible only because surgeons undertook them first on dogs. The work on anemia was possible only through dog experiments. Much is made of the discovery of insulin, of how investigations cost the lives of some 30 dogs, but that thousands of Americans continue to live normally because of the success of these experiments.

The entire history of the development of blood transfusions, of treatment for shock, is closely bound to animal work. Besides these are named experiments leading to the use of vitallium tubes, improved technique for nerve grafts, vaccines, and the testing of many drugs. During the war the dog has contributed toward discoveries that have cut the death rate below any previous figure. Nor is the dog's contribution to medicine completed, for without further experiments in such unsolved disease problems as hypertension, cancer, poliomyelitis, leukemia, etc., these diseases can never be solved.

Anti-vivisectionists generally base their position on three factors. Their first argument is an emotional one. They appeal to dog lovers in behalf of "man's best friend" because the dog cannot speak for himself. This argument has at times enlisted the aid of prominent persons who believed it was a humane society. An example is cited in that Ernest Thompson Seton became a member but resigned upon learning that the organization condemned the work of Pasteur, the Rockefeller Institute, and others.

The second argument is based on cruelty. Anti-vivisectionists cry loud and pitifully of how animals suffer at the hands of a sadistic medical experimenter. This argument is refuted satisfactorily in the pamphlet by describing the care that experimental animals are given and by in-

viting anti-vivisectionists to visit laboratories where research is being conducted.

The third argument represents an unscientific and arbitrary stand. They declare that no one single animal experiment has ever produced a benefit. This position cannot be maintained by anyone who is not completely prejudiced. It represents in effect the denial that vaccinations have value. It ignores all evidence to the contrary. As long as this attitude exists, no argument on an intellectual level will have any effect. It is surprising, therefore, that there are persons of intelligence who today still accept such a declaration. One can as well argue that germs do not exist.

Scattered throughout the pamphlet are anecdotes and quotations illustrating the unsound principles of anti-vivisectionists. For instance, animals have shared equally with man in the benefits resulting from conquest of some of these diseases. In the frenzied effort to spare "man's best friend," do they wish withdrawal of the benefits the dog himself receives? What of rabies for instance, hookworm, distemper, etc?

Another irrefutable argument comes in the form of a question. Medical science will not advance except through experimentation. If these humanitarians object to the use of the dog, would they prefer that human beings be substituted in their place? Dr. Victor Heiser, author of "An American Doctor's Odyssey," once testified before a Senate committee at Washington on one of these bills. In a dramatic way he brought out a bottle containing oil of thyme and explained that it might be of value for hookworm. He asked the committee to assist in the experiment and offered one person one teaspoonful, the second two teaspoonsful, etc. Dr. Heiser explained that he didn't think anyone would die, although some might become ill, but "here is your chance perhaps to save the lives of innumerable human beings—and of dogs as well." Needless to say, the experiment was not continued.

For 50 years continual threats to medical progress have been made by this group. Even though the medical profession explains that pets are not used and that unnecessary pain is never inflicted, even though it is pointed out that many more stray dogs are destroyed by humane societies than are ever used in laboratories, doctors are consistently required to explain their position in this regard. It is no wonder that the medical profession finally becomes impatient and answers as did Dr. Elliott C. Cutler in 1940, as follows:

"Each year new laws are proposed making the use of animals for scientific purposes more difficult. Each year workers in laboratories must stop work and hie themselves to Committee Rooms in the State Houses of our country, there to be maligned as cruel monsters, in order to defend the present laws and to prevent the passage of new laws that would make fruitless the continuance of their efforts for the relief of suffering. The people who attempt such changes in law often wear feathers, plucked in some instances from living birds; they eat meat which is more tender because a farmer without an anesthetic removed a part of the animal's body with a knife when the animal was young; they often wear around their necks furs secured from animals trapped in the north and allowed to freeze to death with a leg broken in a steel trap. Fur trappers have stated that, for every fur brought in from traps, two to five other animals have been eaten from the trap by predatory birds and beasts. And they call scientists cruel! All the laboratory experiments of the last 50 years have not caused as much suffering as the preparation of meat for our markets in a single year."

# 87th ANNUAL SESSION

The 87th annual session of the Kansas Medical Society will be held at Wichita, April 22-25. Superlatives come in abundance when the Committee on Arrangements speaks of the 87th annual session. Most frequently heard are the words "first," "best" and "largest." It is an occasion that will be memorable for a long while and will be recorded as outstanding by comparison with any other of the splendid meetings held in the past.

## First Post-war Session

The 87th annual session is the first to be held after the lifting of wartime bans on conventions. It is the first three-day meeting since 1942. With the exception of one, it is the first occasion since the war when technical exhibits will be presented.

The 87th annual session is the first opportunity for the entire society to convene in general scientific assembly. Present will be civilian doctors who will take advantage of this form of graduate education to learn of scientific developments that have taken place since the war began. Present also will be many of the young men of the Society who have returned from the service who, during the course of the war, have been unable to attend scientific meetings.

This annual session is the first in these and in many other regards. It will mark the opening of a new era in Kansas medicine and will lavishly celebrate along scientific lines as well as from the standpoint of entertainment.

## Scientific Program

Outstanding guest speakers will appear on each of the three days in which general assemblies will be held. They will come from all parts of the country to deliver papers on general subjects as well as a variety in all specialized fields. The complete program will be available soon and will contain names that are known to each doctor in Kansas. Guest speakers have been carefully selected for outstanding achievements in their respective fields and will present material that each doctor in this state will want to hear. The committee reports that probably never before has a more impressive scientific program been presented to the membership of the Kansas Medical Society.

A special EENT section will have a scientific program of interest to all specialists in that field during the three days of the meeting.

## Technical Exhibits

The exhibit hall in the Wichita forum will be arrayed in burgundy velour. More booths are available this year than ever before in the history of the Society. Exhibitors whose contacts with practicing physicians have been curtailed because of material and manpower shortages welcome this opportunity to present their wartime achievements to the profession. More exhibits will be presented than ever before. Representatives of these companies welcome professional interest in their products and most cordially invite each member to visit with them. There will be new products on display and advances in well-known equipment. There will be news regarding production and inspiring stories of what the medical profession may expect in the future. Many familiar companies will be represented and some that have not exhibited with the Kansas Medical Society before, to make this portion of the meeting not only larger but considerably more interesting to the profession than at any time in the past.

## Scientific Exhibits

The medical profession, having been too preoccupied during the past few years to compile material of scientific interest, is now taking time out to gather material for this portion of the annual session. Returning medical officers will add interest and value to the scientific exhibits because there will be displayed material gathered from wartime experience. County societies will co-operate to present projects that have been sponsored in various localities. Special clinics over the state are preparing interesting exhibits concerning their work. Invited also are organizations from selected allied groups, state institutions, the Board of Health and the American Cancer Society. This will be found to be unusual and will bring the visitor back for repeated examination.

## Movic Room

Not since 1942 has a movie room been prepared in connection with the annual session. On this occasion a series of interesting scientific motion pictures will be shown on a variety of subjects, the schedule of which will appear in the official program. This room will be conveniently located on the balcony near the general assembly and will provide instructive information to all doctors who attend the session.

## Round Table Luncheons

Guest speakers will informally discuss topics of specialized interest at various noon luncheons to be held in the nearby hotels. These luncheons frequently have been considered the most interesting portion of the entire session and are open to all who wish to attend. Schedules will be published in the official program and tickets will be available at the registration desk.

## Woman's Auxiliary

The Woman's Auxiliary is planning a program of special interest. Several speakers of national reputation have been invited and will talk on various phases of the socialization of medicine. Present plans include the possibility that one session will be open to the public, at which time a popular lecture on this subject will be given.

## Medical Assistants

On the Saturday and Sunday prior to the annual session, the Kansas Medical Assistants' Society will have an annual meeting. Each doctor in the Society is requested to encourage and if possible to assist his employees to attend this meeting. The program consists of discussions on topics of how greater efficiency may be obtained in the doctor's office. Medical assistants will not only be inspired but will return to their work with progressive ideas on ways in which the profession may better be served. Special attention should be given this important group of people because their successes and failures directly react upon the doctor's practice. Each member is urged to call this to the attention of his assistants so that this portion of the annual session may also be outstanding in its success.

## Annual Banquet

The annual banquet will be held on Wednesday, April 24, and will be the individual high mark of the annual session. An especially fine program has been promised by the committee which every doctor and every member of the Auxiliary will wish to hear. Complete information will be given soon and will also appear in the official

program. This preliminary announcement is called to your attention with the promise that an unusual event will take place on that evening.

### Social Events

Several social events are planned, foremost among them being the golf tournament on Monday afternoon. In the evening the annual golf dinner will be held in all its pre-war glory. Prizes for winners and losers will be distributed at that time. Other social events are planned for various intervals during the annual session to insure the visitor of attractive recreation between the scientific programs.

### IMPORTANT ANNOUNCEMENT

Through arrangements with local hotels, it is believed that all reservations may be cared for. Over-crowded conditions still exist in Wichita, however, and it is imperative that reservations for hotel accommodations be made early. The local committee will give every assistance possible, but it is certain that late registrations will receive less attractive accommodations.

Therefore, as soon as it is known that the doctor can attend the 87th annual session, he should immediately write the hotel of his choice in Wichita for reservations. They are being taken at present. Any person not successful in obtaining a reservation should write Dr. J. E. Wolfe, Beacon building, Wichita, general chairman, or to Mr. Martin Baker, executive secretary, Sedgwick County Medical Society, 1003 Schweiter building, Wichita 2, Kansas.

### New Editor of Iowa Journal

Dr. Everett M. George, recently released from service with the Navy, has assumed the position of editor of the Journal of the Iowa State Medical Society, succeeding Dr. Lee Forrest Hill, who held that position for the past nine years. Dr. George has offices at 505 Bankers Trust Building, Des Moines, Iowa.

### Hospital Dedicated to VA

Winter General hospital, Topeka, was officially dedicated as a Veterans' Administration hospital on Friday afternoon, January 11. In an impressive ceremony invited guests were told by representatives of the Veterans' Administration and others that it was confidently expected that this hospital would become a model for all other institutions treating psychoneurotic disorders. Under the direction of Dr. Karl Menninger and the staff of the Menninger hospital, Winter General will render a great service to the many veterans suffering from mental or nervous disorders.

During the ceremony Col. John W. Sherwood gave an interesting history of the development of Winter General as an Army hospital. At present the institution contains 169 buildings representing an outlay of more than six million dollars. The largest number of patients served in any one month was in July, 1945, when 3,456 were cared for. The total number of patients received at Winter General was 18,523, most of them coming directly from the theaters of operation and all representing special cases that could not adequately be cared for in outlying hospitals.

The Kansas Medical Society wishes to add its congratulations to Dr. Karl Menninger and to his staff for their splendid achievement and wishes the highest measure of success for the future.

### General Lull to AMA

The office of the Surgeon General has announced that Major General George F. Lull, Deputy Surgeon General of the Army, has retired, after 33 years of service with the medical corps, to become secretary and general manager of the American Medical Association. He will take up his new duties officially in July, when the retirement of Dr. Olin West, present secretary and general manager, becomes effective, but he is now on the staff of the AMA familiarizing himself with the work of the organization.

During World War I he commanded a base hospital at Camp Beauregard, Louisiana, and organized and commanded Base Hospital No. 35 of the A.E.F. From 1922 until 1926 he was director of the Department of Preventive Medicine at the Army Medical Center. In 1929 he was appointed medical adviser to the Governor General of the Philippine Islands, where he served for three years, and during the following four years he had charge of the Vital Records Division of the Surgeon General's office.

From 1936 until 1940, General Lull was director of the Department of Sanitation at the Medical Field Service School, Carlisle Barracks, Pennsylvania, and in 1940 he returned to the Surgeon General's office as chief of Personnel Service, serving in that capacity until May, 1943, when he was appointed Deputy Surgeon General. General Lull's record as Deputy Surgeon General won him the Distinguished Service Medal, the highest non-combatant award.

Born in Pennsylvania March 10, 1887, General Lull received his M.D. degree from Jefferson Medical college in 1909, a certificate of Public Health from Harvard Technology School of Public Health in 1921, and his degree of Doctor of Public Health from the University of Pennsylvania in 1922. He is an honor graduate of the 1913 class of the Army Medical School.

### Announces Essay Contest

The Mississippi Valley Medical Society is offering a cash prize of \$100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Society, the Society reserving the exclusive right to first publish the essay in its official publication.

Contributions shall not exceed 5,000 words, and must be typewritten in English in manuscript form. Five copies must be submitted not later than May 1, 1946, to Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209 W. C. U. Building, Quincy, Illinois.

**87th Annual Session  
Kansas Medical Society  
April 22-25, 1946  
Wichita, Kansas**

Biggest meeting in the history of the  
Society.

### **Proposed Amendments to the Constitution**

*In accordance with the provisions of Article XVII of the Constitution of the Kansas Medical Society, the Committee on Constitution and Rules presents for the first time the amendments to the Constitution and By-laws which will be presented to the House of Delegates at the time of the annual session. These amendments, approved by the Council, will be printed twice before the time of the meeting, April 22-25, 1946.*

#### **1. Constitution, Article II—Purposes of the Society.**

Line 7 which now reads, "To secure the enactment and enforcement of just medical laws" shall be amended by eliminating the compulsory and emphatic word "secure," which might be interpreted as influencing legislation, and substituting the advisory word "advocate," making this portion of the Article read, "To advocate the enactment and enforcement of just medical laws."

#### **2. By-laws, Chapter V—House of Delegates—Section 12.**

This section which now reads, "It shall consider and advise as to the material interests of the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto" shall be amended to read, "It shall consider and advise as to the material interests of the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall advocate all proper medical and health legislation and the diffusion of popular information in relation thereto."

#### **3. By-laws, Chapter XI—Committees—Section 24.**

This section now reads, "The committee on Public Policy shall consist of at least three members and in addition the president-elect and the secretary. Under the direction of the House of Delegates and the Council it shall represent this Society in securing and enforcing legislation in the interest of public health, scientific medicine and the medical profession. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people and shall strive to organize professional influence so as to promote the general good of the community in local, state and national affairs and elections. At least one member of this committee shall have served on the retiring committee."

This section shall be amended to read, "The committee on Public Policy shall consist of at least three members and in addition the president-elect and the secretary. Under the direction of the House of Delegates and the Council it shall represent this Society by keeping in touch with professional and public opinion and advocate legislation to secure the best medical results for the whole people and promote the general good of the community in local, state and national affairs and elections. At least one member of this committee shall have served on the retiring committee."

#### **4. By-laws, Chapter XI—Committees.**

Section I shall be amended by the addition of "The Committee on Expert Testimony" to the existing standing committees.

#### **5. By-laws, Chapter XI—Committees.**

This section shall be amended by the addition of a new Section 30 to read as follows: "The Committee on Expert Testimony shall be composed of at least five members of which at least three shall have served on the retiring committee and all members shall be chosen from various sections of the state. By virtue of appointment on this committee, members should avoid serving as expert witnesses in medical matters.

"It shall be the duty of this committee to investigate, analyze and review medical testimony given in any civil, criminal, or personal injury case brought before any of the courts of this state, the industrial commission or Federal Courts when such testimony appears to the court, any of the attorneys, some physicians or any of the principals of the case at issue to have been contradictory, not justified by the physical findings, or one or more of the medical witnesses have consciously deviated from the truth.

"In general their procedure shall be as follows: Upon receipt of a signed written statement from judge, attorney, accusing physician or individual giving names of principals appearing in the trial court or commission in which held and some detail of the alleged improper testimony together with the name of the physician whose testimony is to be investigated, they shall be empowered to secure a transcript of the entire case in question for examination and review. Bill for necessary costs of securing the transcript shall be certified to the Council for payment from Society funds.

"When examination of the transcript by the committee shows merit in the accusation, the committee shall refer the matter to three physicians admittedly expert in the particular type of testimony under consideration for their review with recommendations to the committee. The name of the individual signing the complaint shall not be attached to the papers for review but shall be confidential to the members of the committee only. When review of the case finds the complaint justified one or more of the members of this committee shall discuss its findings with the accused physician, pointing out delinquencies, errors, overenthusiasm, or infractions from proper medical testimony in order to avoid or prevent continuance of such practices. In cases of flagrant character or of belligerency on the part of the offending physician this committee shall be empowered to submit a complete report with transcript to the State Board of Medical Registration and Examination for disciplinary action.

"When evidence points to the possibility of an attorney acting in collusion with an offending physician the committee shall be privileged to present its review of the case to a committee of the Bar Association which may be delegated to consider the ethics of the offending attorney."

### **Distribution of Plasma**

Through a program announced recently by the American Red Cross Kansas will soon receive its portion of the 1,160,000 units of dried blood plasma declared surplus by the Army and Navy. The total amount will be divided among all the states on the basis of population, after the Veterans' Administration has taken a quantity to meet its needs, and Kansas' share is expected to be 12,000 to 15,000 units, an amount estimated as being sufficient to meet the needs of the state for a period of one to two years.

A plan has been proposed for the distribution of plasma through the Kansas State Board of Health, with the Division of Public Health Laboratories in Topeka as the central distribution station. Under this plan, every hospital in the state would receive a supply based on its size, number of patients treated, and the amount of plasma used in the past year, every licensed practicing doctor of medicine would be given one unit to carry with him for emergencies, and every highway patrolman would carry a supply for emergencies.

It is intended that this plan for the distribution of the Red Cross plasma will give the laboratories of the State Board of Health experience in the handling of this product and that sufficient interest will be stimulated to warrant continuing the supply of dried plasma processed from blood donated by the people of Kansas.

# POSTGRADUATE EDUCATION—

Below appears again the map showing donations that have been made to the postgraduate fund. Numbers represent gifts in hundreds of dollars. Figures that are circled indicate that additional gifts have been received since the previous publication of the map in October.

Between the date that the cut was made for the map and the time that material went to the printer, additional gifts were received. The following amounts should be added to the figures listed on the map: Cloud county, \$100; Cowley county, \$400; Kingman county, \$100; Saline county, \$100; Wyandotte county, \$100. These gifts will be added to the map the next time it is published.

Donations to the graduate fund are still being received. If a gift is contemplated, make the check payable to the Kansas Medical Society, Postgraduate Fund. If a bond is purchased for this fund, the bond should be inscribed to the Kansas Medical Society, a Corporation, Graduate Education Fund, 406 Columbian building, Topeka, Kansas.

A committee has been appointed to disburse benefits from this fund, and checks have been written to service men who are or have been taking graduate work. This money has been made available by members of the medical society for medical officers from Kansas who wish to do graduate work. Ex-service men wishing further information on this subject are requested to write Dr. H. H. Jones, Winfield, or the Executive Office.

At present the committee has approved 17 applications and will act on others as rapidly as they are received. The committee requests that all medical officers expecting to take graduate training notify them of the type of course and the dates. It is repeated again that donations from this fund do not represent a loan and are not to be returned. Names of persons receiving benefits from this fund will not be published. The graduate fund represents an expression of gratitude on the part of the Kansas Medical Society to all those men who have served this nation and Kansas medicine during the recent war.

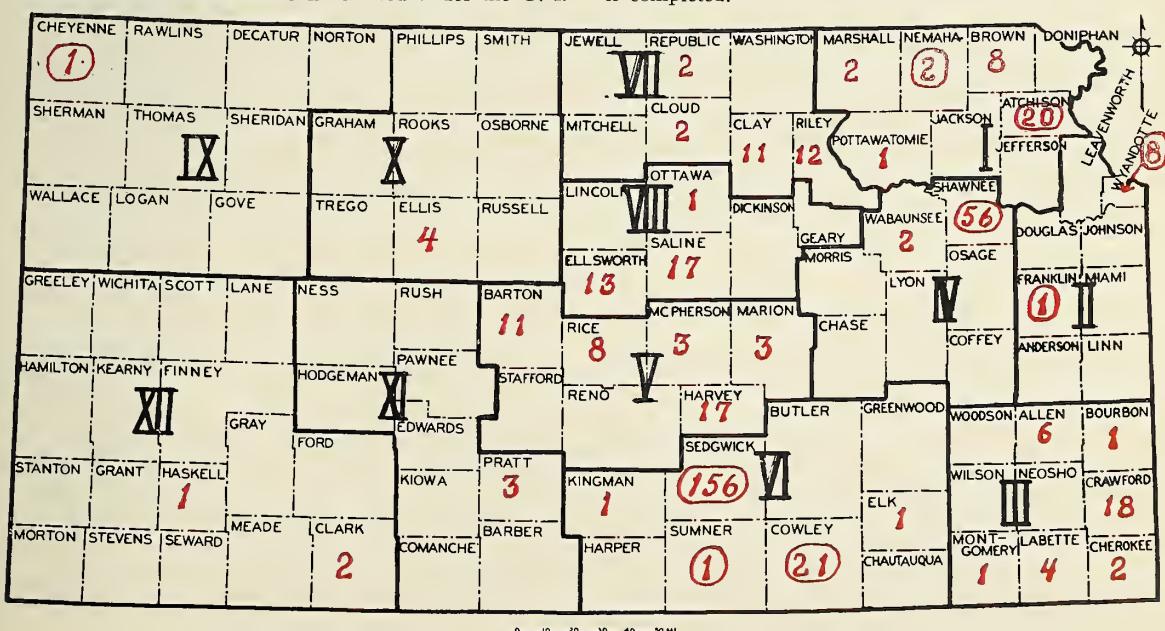
Medical officers will select whatever course of study they wish to take, the length of this course, and the school. Benefits from the graduate fund are available regardless of whether financial assistance is received under the G. I.

Bill of Rights and regardless of whether or not the course selected is approved by national boards. This money is for the purpose of helping to provide for the doctors of Kansas the type of refresher work they want.

The graduate committee is also assisting in numerous other projects. There is close co-operation between the newly organized graduate school of the University of Kansas School of Medicine and the graduate committee. The graduate school, under the direction of Dr. E. H. Hashinger, is now planning courses for the remainder of this winter and next spring. Inquiries as to schedules and recommendations for courses to be offered will be welcomed as Dr. Hashinger and the school have frequently stated that they sincerely wish to be of service to the physicians of Kansas.

Plans are now being made to increase the number of residencies available in the state, in which project the Kansas Hospital Association is co-operating. Civilian members of the society have also expressed their interest in providing refresher courses to medical officers wherever they might be requested. In many localities of the state specialists in the different fields of medicine have volunteered to provide assistantships to those who would like intensive periods of clinical instruction. For participation in this program, the medical officer may inquire of any specialist he selects. Should this application not result in a satisfactory reply, inquiries addressed to the Kansas Medical Society will be forwarded to the specialist. Again, if further information is desired, kindly address the Kansas Medical Society, 406 Columbian building, Topeka, Kansas.

The distribution of new drugs for the necessary preliminary, laboratory and clinical trials is entirely in the hands of the manufacturers. Investigators receiving drugs for this purpose must have proper facilities to carry out the contemplated research accurately and safely. They also may be called on to account for all of the drug supplied and to submit complete reports of their researches which eventually are forwarded to the Federal Security Agency. Obviously, it is impossible for research workers to share their supplies of new drugs before the necessary research is completed.



## THE KANSAS PRESS LOOKS AT MEDICINE

### NEW ZEALAND LEADS THE WAY BACKWARD

A New Zealand doctor frankly describes the shocking breakdown in medical standards in that country as a result of state medicine. Doctor G. M. Smith, medical superintendent of Hokianga public hospital, states "that of every 100 patients who consult a physician today only twenty-five are able to benefit from his advice; that city physicians send twice as many patients to hospitals as they did before hospitalization became free and doctors' consultation fees were guaranteed; that the nation is becoming addicted to the habit of swallowing valueless nostrums from bottles, and that since the great growth of hospitalization there is no efficient control of hospitals, which are publicly financed in this country, and no audit of their results."

What has socialized medicine in New Zealand done to the doctors themselves? Dr. Smith declares that, "The National Medical Association and the politicians of both parties have gone far to foul the name of the profession to which I have the dishonor to belong." The New Zealand state medical system has brought great inflation of the earnings of doctors which are easily concealed from the administration; state stimulus of the practice of collecting large sums for little medical work; disinclination to take difficult cases; use of the system of paying mileage charges to the country doctors to make illegal gains.

Before assuming that this country is too smart to make the errors that in New Zealand have demoralized the medical profession and threaten the health of the people, we will do well to scrutinize our own plans to set up a politically-dominated medical system. Doctors have warned repeatedly that proposals now in Congress would have a disastrous effect on American medical standards.—*Newton Journal*, December 20, 1945

### PROPOSED GOVERNMENT MEDICAL SERVICE

President Truman's proposal for "prepaid personal health service benefits" becomes startling when one considers the cost and, also, the effect on the medical system of this country.

Funds are to be raised by more payroll deductions. He proposes these at four per cent; that is, for a person earning or making \$50 a week, the deduction would be \$2.00 a week.

Compare this with the *Kansas Medical Service* recently announced by our Kansas physicians at 90c a month for single memberships and \$2.25 a month for family memberships. It is true, however, that more is promised under the government plan, the annual cost of which is placed at \$4 billion.

Under it, the Surgeon General of the United States would have the authority to hire doctors, specialists, dentists, nurses, laboratory technicians, and to establish rates of pay. (In this connection, it should not be forgotten that the New Deal politicians count for votes for each government employee.)

The Surgeon General would be authorized also to establish fee schedules for physicians' and dentists' services, fix the qualifications for specialists, determine the number of individuals for whom any doctor or dentist may provide service, determine what hospitals or clinics may provide service for patients and under what conditions, etc.

He would also control grants-in-aid estimated at \$80

million a year for research or professional medical education.

Sounds more like a Russian than an American plan, doesn't it?—*F. N. S., Manhattan Mercury-Chronicle, December 28, 1945*.

### THE PHYSICIANS ACT

The medical doctors of Kansas have taken a noteworthy step forward in their drive to head off the danger of socialized medicine and its attendant evils. Under their sponsorship, Kansas Physicians' Service has been incorporated, thus making available a plan whereby any resident of Kansas can be assured of all needed medical care at a low fixed-fee rate much like regular insurance.

Under this plan any individual may be assured of medical care in all serious illnesses at a cost of 90 cents a month for the individual or \$2.25 a month for married couples or families. The individual would have the right to select any physician he chooses who is a licensed medical doctor.

Such plans as this have been needed for a long time. They are more necessary today than ever before in order to head off socialized medicine under a government setup. Any socialized medicine under any conceivable plan of government control would work out in practice to be no benefit to anyone except the bureaucrats and disciples of regimentation.

The proponents of socialized medicine have plausible arguments. They contend that proper medical care often is too expensive for many people with low incomes. They would place all physicians under some degree of government control, with the government footing the bill for all patients, with money raised from taxation.

The many arguments against socialized medicine may be summed up in the generalization that it would subject the medical profession and everyone it serves to another form of regimentation and political control with all the attendant evils.

If the reader is at a loss to visualize what that means he need but remember how individual and collective food, tire and gasoline problems were handled by the OPA, how the priorities system has been so frequently mishandled by government agencies or what a mess numerous bureaus have made in their efforts to handle labor problems.

Or we might cite the individual inequalities and tragedies traced to bureaucratic muddling within the Veterans' administration.

That better medical plans are needed is certain. That socialized medicine is not one of them is also certain. That the Kansas Physicians' Service is a big step in the right direction it is evident. The plan will produce results. It no doubt will be amended and improved as experience warrants. Meanwhile, our doctors will not be regimented, and neither will the people.—*Kansas City Kansan*.

### A SYSTEM THAT CAN WAIT

An incomplete poll of Congress by the Associated Press reveals opposition to the proposed national and compulsory health insurance system by a vote of about 7 to 4. This is not offered as a decisive index to congressional sentiment but it does have an important meaning especially in relation to past developments.

As a matter of fact this health insurance plan has been proposed in Congress for several years and it has made no progress in all that time. It was given renewed public attention but no more than the usual response from Congress when the President urged its adoption about two months ago.

A majority of the medical profession believes the sys-

tem would be highly detrimental to health and medical standards. It is far-reaching and complicated, covering an estimated 110 million of the population and with separate provision for federal, state and railroad employees and their families. Its estimated cost would be 3 billion dollars a year.

The cost and methods of financing alone are an immense problem. Employees might be required to pay anywhere from 4 to 5 per cent in pay roll taxes, compared with 1 per cent today, and even then the government would have to help bear the cost. No financing plan has been worked out.

In the meantime the nation's health standards have made steady progress and its health showing is the best in the world, better even than that of European countries which have the compulsory system. Hospitalization, prepared medical plans and private insurance systems are covering increasing millions of the people in America. It is the threat to such progress that is believed to be the greatest danger in the federalized and compulsory system—in which perhaps a majority of the medical profession would not participate and which millions of people might be unable to use while being forced to help pay the cost.

Other phases of the administration program have met less opposition and may be adopted. With some qualifications they are favored by the medical profession as by congressional sentiment. They are not radical in nature and are calculated to encourage what now is being done. They include the broadening of the nation's health program, aid for the construction of hospitals and other medical facilities, expansion of maternal and child health services, promotion of medical research and education, and sickness and disability insurance for workers.

Added to the service already available these various forms of assistance surely would be enough for the present and would be a powerful aid to health advancement. The doubtful and extremely expensive compulsory system can wait. It can wait while the service and the health standards of the American people grow constantly better.—*Kansas City Times, January 16, 1946.*

Efforts of the doctors, including their hokum and quackery as well as their superb surgical and medical skill, is probably the most appreciated of all the professions. No doubt this is partly the reason why so many folks are happy to have members of the medical profession out of the army and back into private practice. Those who stayed at home and attempted to cure all of the real and imaginary ailments did their very best but it was not enough. Their number of successes and failures ran along at about the same rate but their public relations job was terrible because they forgot all about it. Socialized medicine got a big boost during the war and the doctors caused most of it.—*Lawrence Outlook, December 13, 1945.*

#### Appointments with Veterans' Administration

Information received at the executive office indicates that physicians seeking appointment as Junior or Associate Medical Officers with the VA should make application to the manager of the nearest VA regional office, hospital or center, where appointments can be made subject to a post-audit of qualifications at Washington. Those interested may address A. R. Pearce, M.D., chief medical officer, Veterans' Administration, Wichita 2, Kansas, or the office at Washington, D. C.

Child Mortality 200 Years ago—In the eighteenth century, seventy-five per cent of the children died before they were five years old.—*Science News Letter.*

#### Department of Medicine and Surgery in VA

A Department of Medicine and Surgery was created in the Veterans' Administration recently when the President signed H.R. 4717, bringing professional personnel into an organization comparable with the Army and Navy Medical Corps and the U. S. Public Health Service. General Paul R. Hawley will serve as Acting Chief Medical Director.

Under this arrangement the Veterans' Administration will be able to offer more attractive opportunities to the 1,125 doctors, 1,200 nurses and 100 dentists needed to fill vacancies. Those now employed by the VA will be continued on their present jobs pending determination of their qualifications for appointment in the new medical department.

Among the major provisions of the new act are the following:

1. Specialists certified by VA will be paid 25 per cent more salary up to a ceiling limit of \$11,000 a year.
2. Residencies will be set up in VA hospitals where younger doctors may study to qualify as specialists. This will mean that veterans will be able to obtain the most up-to-date medical treatment—the same kind as if they were admitted to hospitals connected with the nation's leading medical schools and centers.
3. Promotions will be made on recommendations of special VA boards which, in general, compare with the "selection boards" operating in the Army and Navy for higher ranking officers.

The director of the department will receive a salary of \$12,000 per year, a deputy will be paid \$11,500, and assistants, not to exceed eight in number, will be paid \$11,000 each. Other grades of medical service, listed downward from chief, senior, intermediate, full, associate and junior, will receive salaries ranging from \$9,800 to \$3,640.

Another provision of the act will permit professional improvement of VA medical personnel by allowing up to five per cent of such employees to study or do research work for periods of time up to 90 days, enabling them to keep abreast with the latest developments in their respective fields.

#### New Attorney for Board

Mr. Blake A. Williamson, Kansas City, has been appointed attorney for the Kansas State Board of Medical Registration and Examination, according to an announcement made recently by Dr. J. F. Hassig, Kansas City, secretary of the Board. Before leaving his practice to serve in the Army, Mr. Williamson was a member of the Kansas House of Representatives.

**87th Annual Session  
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Hotels are crowded. Make your reservations now!

## MEMBERS

Dr. M. D. McComas, Jr., who was released from active duty with the Army in December, has returned to his practice in Courtland, where he is associated with his father, Dr. M. D. McComas.

\* \* \*

Dr. Andrew E. Rueb, who served as a captain in the Army medical corps for three years, has returned to his practice in Salina. While in the service he spent eight months in the Aleutians, returned to the United States, and was later assigned to duty in England.

\* \* \*

Dr. T. G. Duckett, who practiced in Sheldon, Missouri, before the war, has opened an office in Hiawatha. He is a graduate of the University of Kansas School of Medicine. During the war he served as a major with the 77th evacuation hospital in the ETO.

\* \* \*

Dr. Cecil C. Hunnicutt, formerly of Los Angeles, has announced that he will begin practice in Saberha in March, after he completes a postgraduate course in surgery at Cook County hospital, Chicago. For the past 38 months he has been in the Army, recently as chief of the surgical staff at the Grand Island, Nebraska, air field.

\* \* \*

Commander A. J. Rettenmaier has been discharged from the Navy and is returning to his practice in Kansas City. Early in the war he was assigned to duty at Great Lakes and at Notre Dame university, and during recent months he had sea duty aboard the USS Matthews in the South Pacific.

\* \* \*

Dr. H. Penfield Jones, Lawrence, who recently returned to his practice after receiving his Army discharge, has been notified that he was promoted to the rank of lieutenant colonel several months before his discharge. The delayed news reached him while he was on terminal leave.

\* \* \*

Dr. J. Allen Howell, who was associated with the Hatcher clinic, Wellington, before entering the Army medical corps, has announced the opening of a private office in Wellington. During his three years' service with the armed forces, Dr. Howell was assigned to duty with the 8th Air Force in England.

\* \* \*

Dr. H. R. Barnes, who has been stationed at Fitzsimmons hospital, Denver, for the past three and a half years as a specialist in chest diseases, has been discharged from the Army and is resuming his practice in Hutchinson.

\* \* \*

Dr. L. F. Eaton, who was discharged from the Army in December after three and a half years' service, has resumed practice with the Mowery clinic, Salina. As a major in the medical corps, Dr. Eaton was assistant chief of the general surgery section at Smoky Hill air field for some time before going overseas in October, 1944, as chief of the urology section of the 193rd general hospital. The unit was stationed in Scotland, England and France.

\* \* \*

Commander A. D. Danielson has been discharged from the Navy and is re-opening his office in Herington. While in the Navy he served overseas for 20 months as senior medical officer aboard the USS Appalachian, saw action at Guam and Leyte, and participated in the occupation of Japan. Upon his return he announced that Dr. J. O.

Gilliland, formerly of Pampa, Texas, will be associated with him in practice. Dr. Gilliland was recently released from the Army medical corps.

\* \* \*

Dr. M. C. Ruble was elected president of the Mercy hospital staff, Parsons, at a meeting held last month. Dr. T. D. Blasdell was named vice president, and Dr. R. W. Urié was elected secretary.

\* \* \*

Dr. A. C. Irby has returned to Fort Scott as a member of the staff at the Newman-Young clinic. He was recently released from the Navy after three years' service. After a year in the Aleutians, he was transferred to the Central Pacific aboard the transport USS Bollinger.

\* \* \*

Major George R. Maser is now on terminal leave after three years' service in the Army and is re-opening his office in Mission.

\* \* \*

Dr. C. B. Johnson, Eudora, has moved to Lawrence and has opened an office there. He is a member of the staff at Lawrence Memorial hospital.

\* \* \*

Dr. Philip H. Hostetter, who was recently released from the Army after having served 23 months in the Pacific, is opening an office in Baldwin this month. He is a graduate of the University of Kansas School of Medicine.

\* \* \*

Dr. Funston J. Eckdall has returned to his surgical practice in Emporia after an absence of three and a half years while he served as a major in the Army with the 76th station hospital in the Southwest Pacific.

\* \* \*

Dr. Carl Stansaas, who returned to the United States last fall after serving in the Army overseas, has announced the opening of his office in Arkansas City.

\* \* \*

Dr. M. E. Robinson, who practiced in Burlington, Colorado, before entering the Army, has announced that he will practice in Goodland in association with Dr. M. I. Renner.

\* \* \*

Dr. Carl J. W. Wilen, who was recently released from the Army after three years' service, has announced the opening of an office in Manhattan. Before entering the service he was an instructor in the department of medicine at Tulane university. He is a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians and of the American College of Chest Physicians.

\* \* \*

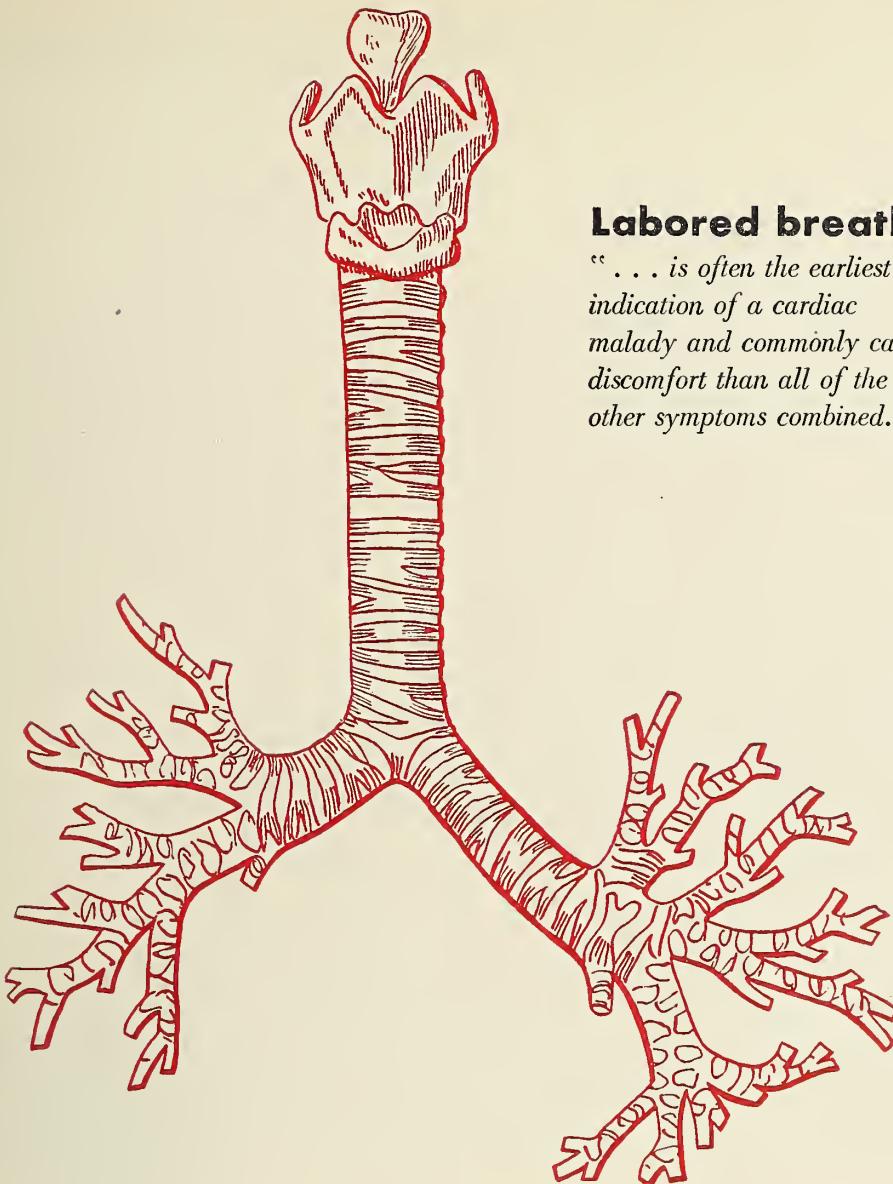
Dr. Charles S. Brady has returned to his practice in Atchison after an absence of two and a half years while he served as battalion surgeon with the 754th Tank Battalion in the Pacific.

\* \* \*

Dr. Harold V. Holter and Dr. Thomas J. Sims are re-opening their office in Kansas City this month. Dr. Holter, as a commander in the Navy attached to the marine air wing, spent 40 months in the service, 16 months in the Pacific area. Dr. Sims was also in the service 40 months, serving as a lieutenant colonel in the Army.

\* \* \*

Dr. John S. Betz, Kansas City, who has been serving in the Army as ophthalmologist in station hospitals in Nebraska and Idaho for the past three years, has been released from the service and will be associated in practice with Dr. J. A. Billingsley.



## Labored breathing...

*"... is often the earliest indication of a cardiac malady and commonly causes more discomfort than all of the other symptoms combined."<sup>1</sup>*

**AMINOPHYLLIN-SEARLE**, by relaxing the bronchial musculature, encouraging resumption of a more normal type of respiration, reduces the load placed on the heart and helps prevent further damage.

Aminophyllin-Searle is indicated in paroxysmal dyspnea, Cheyne-Stokes respiration, bronchial asthma (particularly in epinephrine-fast cases) and in selected cardiac cases.

Aminophyllin-Searle contains at least 80% anhydrous theophyllin. G. D. Searle & Co., Chicago 80, Illinois.



1. Harrison, T. R.: *Cardiac Dyspnea*,  
*Western J. Surg.*, 52:407 (Oct.) 1944.

Dr. G. Kenneth Lewis, who recently returned to his home in Garden City after having been released from the Army, has announced that he will join the staff of a Chicago hospital and will limit his practice to plastic surgery. Dr. Lewis, who was promoted to the rank of full colonel before his discharge, was in charge of plastic surgery work in the ETO.

\* \* \*

Commander Robert M. Carr, now on terminal leave from the Navy, has announced that he will return to his practice in Junction City in association with his father, Dr. W. A. Carr, and Dr. W. A. Smiley. During his Navy duty Dr. Carr served 16 months aboard an aircraft carrier in the Pacific.

\* \* \*

D. Donald A. Anderson, Dr. L. F. Eaton and Dr. Andrew Rueb, Salina, were named president, vice president and secretary, respectively, of the Asbury hospital staff at a meeting held January 7.

\* \* \*

Lt. Col. James B. Weaver, Kansas City, formerly stationed at Fort Leavenworth, has been assigned to Personnel Service, Military Personnel Division, Procurement, Separation and Research Branch, Office of the Surgeon General.

\* \* \*

Dr. G. L. Norris, associate of the Snyder-Jones clinic at Winfield, has been granted a year's leave of absence to enter Washington university at St. Louis to study heart disease.

\* \* \*

Dr. Lucien R. Pyle, who has been in the Navy since April, 1942, is now on terminal leave and is preparing to open his office in the National Reserve building, Topeka. As Commander Pyle he was stationed at the Navy hospital in Brooklyn in the department for care of dependents.

\* \* \*

The Clay County Medical Society has announced the return from service of three of its members who have reopened their offices in Clay Center, Dr. Bruce McVay and Dr. G. B. McIlvain, who served in the Army, and Dr. S. A. Anderson, who was with the Navy.

\* \* \*

Dr. Francis M. Stone, Jr., who recently returned from 21 months' service overseas as an Army surgeon, has opened an office at Kincaid. He is a graduate of Tulane university medical school and served his internship at Kansas City General hospital.

\* \* \*

Dr. Byron J. Ashley, who was recently released from the Navy with the rank of commander, is returning to his practice in Topeka. During his service of more than three and a half years, Dr. Ashley spent a year in the Pacific.

\* \* \*

The Parsons clinic, organized recently by Doctors Charles H. Miller, M. C. Ruble and R. W. Urié, has announced the names of three new members of the staff, Doctors Guy W. Cramer, Earl A. Martin and Charles Henderson, all of whom were recently released from the service.

\* \* \*

Dr. Harry J. Bowen is returning to his practice in Topeka after having spent three and a half years in the Army, 20 months overseas in England and France. He is associated in practice with his brother, Dr. James D. Bowen.

\* \* \*

Dr. G. F. Helwig returned to his practice in Topeka last month after having served in the Navy for several years.

Dr. Guy A. Finney, who served in the Army 38 months and was released recently with the rank of lieutenant colonel, has returned to Topeka and is resuming his practice of radiology in association with Dr. A. K. Owen.

\* \* \*

Dr. Omer M. Raines, on terminal leave from the Army, is returning to Topeka and is opening an office in the National Reserve building.

\* \* \*

Major Max E. Kaiser, who practiced in Ottawa as a civilian, recently received the Bronze Star for distinguished surgical service aboard an Army hospital ship that operated in the Southwest and Central Pacific battle areas during 1944-1945. The citation follows:

For meritorious achievement aboard a hospital ship in the Southwest Pacific, from 7 November 1944 to 12 March 1945, and in the Central Pacific from 13 April to 16 May 1945, in connection with military operations against the enemy. As chief of surgical service of a hospital ship Major Kaiser performed surgical operations on evacuated casualties aboard his ship in dangerous waters liable to enemy air attack. The ship closely followed combat operations to remove casualties to rear echelon medical installations. Throughout these arduous missions, he labored tirelessly to handle all surgical cases brought aboard with a minimum of delay, often working 24 hours straight. He inspired his whole staff to render desperately needed emergency surgical treatment with untiring dispatch and efficiency. As a result, many of the 4,587 casualties evacuated by this ship were treated within a very few hours after they had been hit and all received the best of surgical care. By his outstanding surgical ability and devotion to duty, Major Kaiser made an important contribution to success in this mission.

### New Aids in Physical Diagnosis

"New Aids in Physical Diagnosis" is the title of a discussion given by Dr. Ralph H. Major, professor of medicine at the University of Kansas School of Medicine, over a coast-to-coast network on January 22. The broadcast was one of a series of programs presented weekly by Lederle Laboratories, Inc., over the American Broadcasting Company network.

### Red Cross Names Advisory Board

Two Kansans, Dr. F. C. Beelman, secretary of the Kansas State Board of Health, Topeka, and Dr. Karl A. Menninger, Topeka, have been named members of an Advisory Board on Health Services to coordinate activities of the American Red Cross in the health field, according to an announcement made recently by Basil O'Connor, national Red Cross chairman. Dr. Lewis H. Weed of Baltimore, chairman of the medical sciences division of the National Research Council and director of the School of Medicine at John Hopkins university, will serve as chairman of the advisory board.

### Kansan On Investigating Committee

Dr. James B. Weaver, a member of the staff of the School of Medicine at the University of Kansas, was named head of a committee appointed by Secretary of War Patterson for the purpose of investigating conditions in Army hospitals in this country with reference to the release of medical officers. The committee is making a complete circuit to investigate every service command of the Army. Dr. Weaver, who had served as a lieutenant colonel during the war, was recalled from terminal leave for the investigation.



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## DEATH NOTICES

### D. W. RELIHAN, M.D.

Dr. D. W. Relihan, 91, an honorary member of the Smith County Medical Society, died at his home in Smith Center January 6. A graduate of Rush Medical college with the class of 1896, he had practiced continuously in Smith Center until his retirement in 1941.

### LESLIE CARR BISHOP, M.D.

Dr. Leslie C. Bishop, 63, a member of the Sedgwick County Medical Society, died January 6 while visiting in Altadena, Calif. A native of Canada, Dr. Bishop was graduated from McGill University, Quebec, in 1903. He was associated with the Topeka State hospital before opening his office in Wichita in 1916, limiting his practice to psychiatry and neurology.

### CHARLES H. FORTNER, M.D.

Dr. Charles H. Fortner, 72, who had practiced medicine and surgery in Coffeyville for more than 40 years, died at his home January 11. He was a graduate of the University Medical College of Kansas City with the class of 1904.

### EUGENE E. WALLACE, M.D.

Dr. Eugene E. Wallace, 66, Kingman county physician for the past 40 years, died at his home at Norwich January 11. He was graduated from the University of Illinois College of Medicine, Chicago, in 1905, and during his years of practice specialized in pediatrics.

### JOHN W. WEST, M.D.

Dr. John W. West, 73, died at his home in Narka January 2 after an illness of many years. Bedfast for the last six years of his life, he continued to administer to patients who came to him. He was a graduate of Lincoln Medical College, Lincoln, Nebraska, and had practiced a short time at Lantham before opening his office in Narka in 1902.

### TRACY R. CONKLIN, SR., M.D.

Dr. Tracy R. Conklin, 78, died at his home at Abilene January 19. He was graduated from the St. Louis College of Physicians and Surgeons in 1898 and had practiced continuously in Abilene since that time. He was an active member of the Dickinson County Medical Society. Surviving are three sons who are also members of the society, Dr. T. R. Conklin, Jr., Dr. K. E. Conklin, and Dr. Q. D. Conklin.

### CHARLES F. ATTWOOD, M.D.

Dr. Charles F. Attwood, 63, Topeka physician, died suddenly Christmas day while visiting at the home of his daughter in Kansas City. He had practiced in Topeka for 21 years, limiting his work to proctology.

A graduate of the Kansas Medical College, Topeka, he was licensed in 1906 and began practice in Marshall county, where he spent several years before moving to Topeka.

## Honor Junction City Doctors

Doctors in Junction City and surrounding territory were guests of honor at a luncheon given by the Junction City Chamber of Commerce January 24, a gathering planned to give special recognition to the physicians who served in the armed forces as well as those who remained in civilian practice during the war. An informal program followed the luncheon.

## Central Kansas Medical Society

A quarterly meeting of the Central Kansas Medical Society was held at the Ellsworth country club January 17. During the afternoon the following scientific program was given: "Rheumatic Heart Diseases," Dr. Don Carlos Peete, Kansas City; "Newer Trends in Anesthesia," Dr. Paul H. Lorhan, Kansas City; "War Medicine," Mr. Clarence Munns, Topeka. Dinner was served after the meeting.

## Golden Belt Society Meets

A quarterly meeting of the Golden Belt Medical Society was held January 3 at the Lamer hotel, Abilene. During the afternoon the following scientific program was given: "Oblique Inguinal Herniae", Dr. L. V. Hill, Kansas City; "Pregnancy Complicating Diabetes", Dr. Robert H. Maxwell, Wichita; "Urology in the Female", Dr. O. W. Davidson, Kansas City; "Pneumothorax", sound film, State Board of Health, Topeka. After the dinner hour Dr. F. C. Beelman, secretary of the State Board of Health, Topeka, discussed recent legislation affecting the doctor and public health.

## County Societies

The Bourbon County Medical Society met January 16 at the Burke Street hospital, Fort Scott, with a full representation present, the first time since the start of the war. The following doctors, all recently released from the service, were welcomed: Doctors A. C. Irby, Robert S. Young, Raymond Gench, L. L. Cooper and Leland Randles. A round table discussion of cases handled during the month followed a luncheon.

\* \* \*

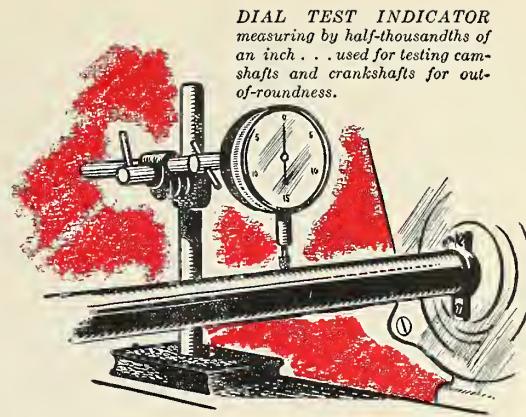
Dr. Russell R. Cave of Manhattan, councilor for the seventh district, addressed members of the Cloud County Society January 15 at Concordia. He discussed plans for the medical care of veterans in their home communities.

\* \* \*

Twenty-one members and guests attended a meeting of the Labette County Society held at Parsons January 8. Dr. W. W. Bauer, of the A.M.A., spoke on medical legislation and civic responsibilities of the profession.

**87th Annual Session  
Kansas Medical Society  
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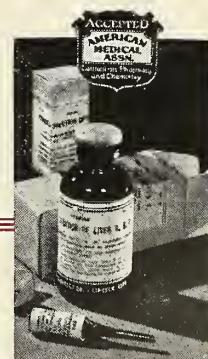
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### Pediatrics Refresher Course at K. U.

A postgraduate course in pediatrics will be given at the University of Kansas School of Medicine, Kansas City, February 25 to March 1, inclusive, under the auspices of the Division of Graduate Medical Education of the school, the Kansas State Board of Health, and the Child Welfare committee of the Kansas Medical Society.

The following program has been arranged:

Monday, February 25

- 8:00 a.m.—Registration
- 9:00 a.m.—The First Few Minutes—Dr. Leroy A. Calkins
- 10:00 a.m.—Hospital Facilities For The Care of Newborn Infants (Part I)—Dr. Ethel C. Dunham
- 11:00 a.m.—Recess
- 11:30 a.m.—The Feeding of Premature Infants—Dr. Harry Gordon
- 12:30 p.m.—Luncheon
- 1:30 p.m.—Hospital Facilities For The Care of Newborn Infants (Part II)—Dr. Ethel C. Dunham
- 2:30 p.m.—Methods of Reducing Neonatal Hazards For Premature Infants—Dr. Harry Gordon
- 3:30 p.m.—Erythroblastosis Fetalis—Dr. George V. Herrman

Tuesday, February 26

- 9:00 a.m.—The Child Welfare Conference—Dr. Paul R. Ensign
- 10:00 a.m.—Individualization in The Feeding of Infants—Dr. Harry Gordon
- 11:00 a.m.—Recess
- 11:30 a.m.—Thumb-sucking And Other Behavior Disturbances in Infants—Dr. Robert R. Sears
- 12:30 p.m.—Luncheon
- 1:30 p.m.—Speech Training of Children—Miss Quintilla Anders
- 2:30 p.m.—Toilet Training—Dr. Robert R. Sears
- 3:30 p.m.—Psychometric Testing in Children—Miss Margaret Ivy

Wednesday, February 27

- 9:00 a.m.—The Treatment of Meningitis—Dr. Donald N. Medearis
- 10:00 a.m.—Personality Problems in Early Infancy—Dr. Robert R. Sears
- 11:00 a.m.—Recess
- 11:30 a.m.—Kenney Treatment of Poliomyelitis—Dr. Gordon M. Martin
- 12:30 p.m.—Luncheon
- 1:30 p.m.—Convulsive Disorders in Children—Dr. A. T. Steegmann
- 2:30 p.m.—Neurological Examination of Children—Dr. Wm. P. Williamson

3:30 p.m.—Mental Health Problems in Children—Dr.

Herbert C. Miller

Thursday, February 28

- 9:00 a.m.—Histoplasmosis—Dr. Leo Furculow
- 10:00 a.m.—Tuberculosis—Dr. H. L. Hiebert
- 11:00 a.m.—Recess
- 11:30 a.m.—Streptococcosis—Dr. Paul Boisvert
- 12:30 p.m.—Luncheon
- 1:30 p.m.—Epidemic Diarrhoea in Great Bend, Kansas, in 1945—Dr. F. C. Beelman
- 2:30 p.m.—Symposium on Immunization Procedures: Dr. Fred Mayes, Chairman
- Diphtheria—Dr. George V. Herrman
- Measles Prevention—Dr. Donald N. Medearis
- Pertussis—Dr. Robert C. Fredeen
- Smallpox—Dr. Fred Mayes
- Tetanus—Dr. John Aull

Friday, March 1

- 9:00 a.m.—Relation of Government to Maternal and Child Health—Dr. Hester Curtis
- 10:00 a.m.—H. Influenza, Type B, Infections—Dr. Paul Boisvert
- 11:00 a.m.—Recess
- 11:30 a.m.—Acute Infectious Encephalitis—Dr. Carl Ecklund
- 12:30 p.m.—Luncheon
- 1:30 p.m.—Dental Diseases and Anomalies in Children—Dr. Leon Kramer
- 2:30 p.m.—Pertussis—Dr. Paul Boisvert
- 3:30 p.m.—Appendicitis in Children—Dr. Thomas G. Orr

Speakers who are not members of the faculty at the school are:

F. C. Beelman, M.D., secretary and executive officer, Kansas State Board of Health, Topeka, Kansas.

Paul Boisvert, M.D., assistant professor of pediatrics, Yale University School of Medicine, New Haven, Connecticut.

Ethel Dunham, M.D., formerly director of research, Children's Bureau, Department of Labor, Washington, D.C.

Hester Curtis, M.D., regional medical director, Children's Bureau, Department of Labor, Kansas City, Missouri.

Carl Ecklund, M.D., assistant surgeon, U. S. Public Health Service, Kansas City, Kansas.

Leo Furculow, M.D., surgeon, U. S. Public Health Service, Kansas City, Kansas.

Harry Gordon, Major, M.C., U.S.A., assistant professor pediatrics, Cornell University Medical college, New York, New York.

Robert R. Sears, PhD., director, Iowa Child Welfare Research station, University of Iowa, Iowa City, Iowa.



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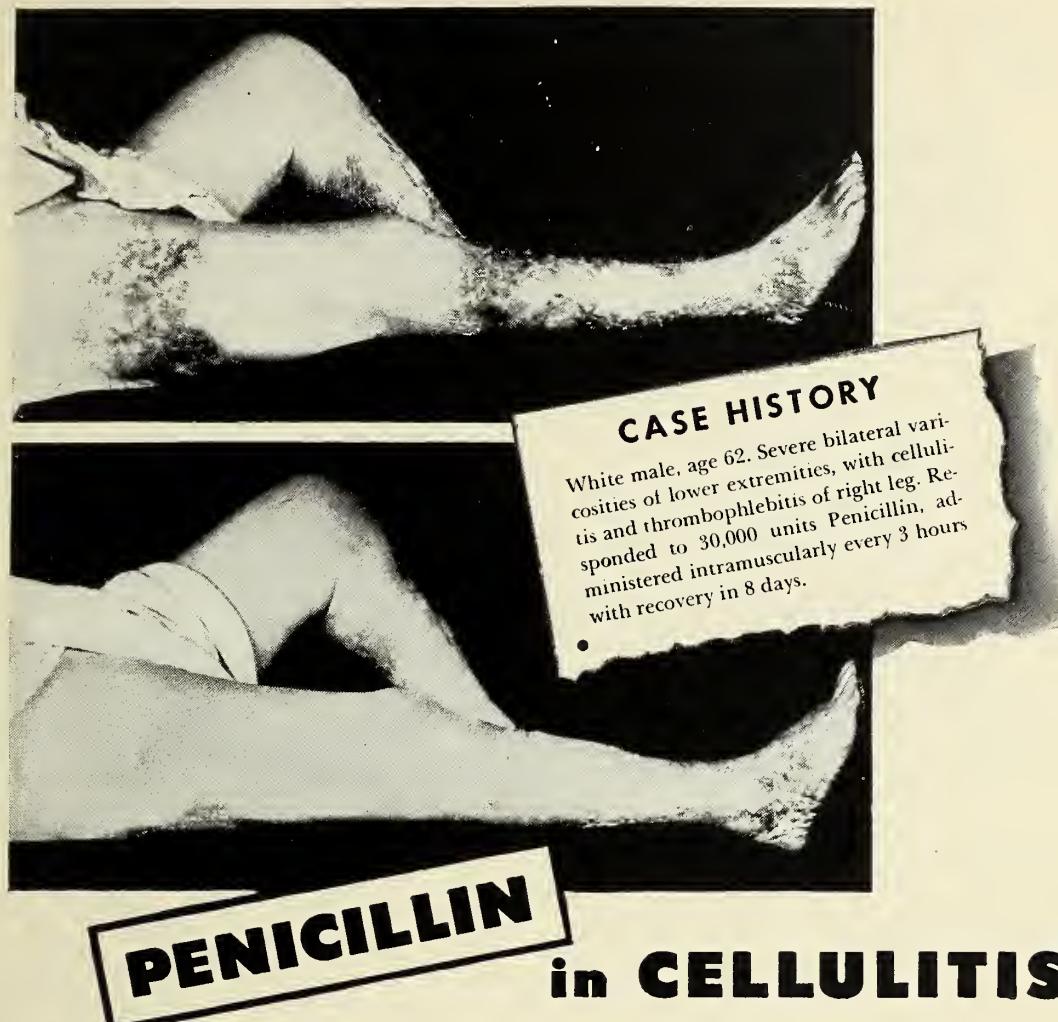
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Bristol Penicillin, because of its low toxicity and freedom from pyrogens, its absolute sterility and standard potency, provides dependable therapeutic action.

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\*Keefer C. S. et al.: New Dosage Forms of Penicillin, J.A.M.A. 128: 1161 (Aug. 18) 1945.

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## KANSAS MEDICAL ASSISTANTS' SOCIETY

### Constitution and By-laws

*In accordance with the provisions of Article VI, Section 1, of the constitution of the Kansas Medical Assistants' Society, the proposed new sections of the constitution and by-laws are printed below in lieu of written notice to each component society. Each section herewith presented is to replace the section of the same number in the constitution and by-laws currently in force, with the exception of Chapter V, Section 3, which is an addition.*

#### By-laws, Chapter I, Section 2

Active members shall be individuals employed as medical assistants by members of the Kansas Medical Society or medical assistants employed in hospitals or institutions whose superintendent, or the majority of whose professional staff shall be composed of members of the Kansas Medical Society. Active membership shall terminate immediately after the above qualifications no longer apply.

#### Chapter I, Section 3

Associate members shall be individuals employed in the capacity of medical assistants in offices or hospitals recognized by the Medical Advisory Board to be ethical, but the majority of whose professional staff is not composed of members of the Kansas Medical Society. By official action at an annual session, an associate member may become an active member provided that two years' continuous membership immediately precedes such action.

#### Chapter III, Section 1

The nomination of the first president shall be made from the floor. The annual nomination for president-elect, vice president, secretary, and treasurer shall be made from the floor with a minimum of two nominations for each office. In the election of all officers, a majority of all votes cast shall be necessary for election, and when more than two candidates are considered, if after the second ballot an election is not held, the name receiving the lowest number of votes shall be dropped and a vote cast on the remaining candidates.

#### Chapter III, Section 2

The election to fill expired terms of councilors by their own districts shall be a part of the annual meeting; the results of these elections to be announced with those of the annual election of other officers. In the event of death, resignation, or removal of any councilor during her term of office, the president may appoint a successor to serve until the vacancy is filled at the next annual session. No councilor shall be eligible to serve for more than two successive terms. No member holding another office may serve as councilor.

#### Chapter V, Section 3

Members of the Executive Council shall be allowed first-class rail fare or its equivalent for one meeting per year. This expense is to be paid from the treasury.

#### Chapter VI, Section 1

The annual meeting shall be held at a place and time to be decided upon by the Executive Committee or Council. Special meetings may be held at the call of the Executive Committee or Council by giving written notice mailed to the address of each member at least ten days in advance of said meeting, or by publication in the Journal of the Kansas Medical Society at least thirty days in advance of said meeting.

### Chapter VIII, Section 1

These by-laws may be amended by a two-thirds vote of the members present at the business session of the annual meeting, provided, that the proposed amendment shall have been read in open meeting at the preceding annual session or shall have been printed in the Journal of the Kansas Medical Society at least one month prior to the meeting, or that it shall have been sent to each component society not less than ten days before the annual meeting.

### Helping the Doctor Collect His Money\*

#### Part V

By David Morantz, Kansas City, Kansas

One of my pet hobbies has been to dig up and develop new and different ways of tracking down the ubiquitous skip, the debtor who moves without giving you his new address.

You will find many skips by watching the newspaper for news items wherein some debtor of yours may be mentioned.

Read the Birth Notices, Marriage Licenses and Society columns of your newspaper and you will be surprised at the number of your lost debtors you will find that way as well as new addresses on good patients.

However, the most fruitful of all sources of information is the little newspaper death notice. Read every death notice carefully, not only for the name of the deceased, but for the survivors and for other invaluable information contained therein. Often one of the survivors is a person who owes you an account. This gives up-to-the-minute information on every member of that debtor's family. It also gives the name of the funeral director and sometimes the cemetery, the minister who officiated at the services, as well as the names of the pallbearers who were, of course, close friends of the family. We have located hundreds of skips in this way.

Watch for the return address on the envelopes containing letters or payments from good-paying patients. Often a debtor will move, forgetting to notify you of his new address and these sources of information will help bring your records up to date on good accounts as well as furnish you with many new addresses on skips.

Note the address of the remitter on money orders received. This information has enabled us to correct our records on many accounts when the debtor overlooked telling us of his new address.

Often a parent will refuse to disclose the address of a son, when there is a suspicion that the information is wanted for the purpose of collecting a debt. This difficulty can usually be overcome if you intimate that you are an old friend of the son who is trying to locate him to repay a loan.

Or you might say: "I heard that he was looking for a better job. I know of a good place he might be able to get, but I've got to talk to him at once about it or it may be too late." When a "good job" is in sight, the parent will usually lose no time in telling you exactly how you can reach the offspring.

Often it is necessary to conceal your real purpose in your efforts to locate a debtor who is intentionally covering up his tracks to avoid paying his just bills. Is this justifiable in bringing to justice the deadbeat, who, himself, uses every kind of subterfuge to avoid paying what he justly owes?

I feel that it is and I believe that everyone who has anything to do with collecting from such debtors will agree with me on that point.

\*From an address delivered before the Wyandotte County Medical Assistants' Society.

*Y-tube permits either interrupted or continuous nebulization of penicillin*

*Nasal tip is connected with same apparatus*



## NEW METHOD of Penicillin Inhalation Therapy

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The aerosol apparatus illustrated allows rebreathing of the nebulized penicillin solution

and increases local deposition of the drug on the bronchopulmonary surface.

Space does not permit detailed description of this new therapeutic method. The makers of Penicillin Schenley have prepared for the use of physicians, a descriptive folder which is yours for the asking.

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## AUXILIARY

### President's Message

Call to action!!!

To all women associated with or interested in the medical profession.

In our last message to you, we attempted to create interest in the currently proposed national legislation which, if enacted, will abolish the private practice of medicine, dentistry, and hospitalization.

In contrast, we are now presenting the substitute program adopted by the physicians of the Kansas Medical Society.

May we now arise from this consuming lethargy of indifference, lack of knowledge, or whatever the cause, and meet the challenge of the American Medical Association in spreading this information to the public in an effort to defeat this vicious attempt to socialize medicine. Let the laity know that it is for their benefit much more than for the benefit of men in medicine.

Study this state plan. Know whereof you speak, and SPEAK WHAT YOU KNOW. This is a vital matter.

Seriously and sincerely,  
Mrs. Hugh A. Hope.

### What You Should Know About KPS

Kansas Physicians' Service has become a reality. The countless hours of planning are at an end as this greatest venture in the history of the Kansas Medical Society takes form. Broad policies have been outlined and approved.

No one claims that a Utopian era for medicine will be ushered into being with the birth of Kansas Physicians' Service. No one connected with the plan expects it to operate without dissatisfaction. No one thinks every doctor and every patient will immediately find this the perfect answer to all their problems.

It will, however, provide certain advantages that are not available today, and it is an answer to the proponents of socialized medicine.

True or false, it has been claimed by many that the economic hazards involved in catastrophic illness frequently prompt the patient to delay seeking medical care. When received its cost leaves the patient in debt. And for the doctor this patient is a poor financial risk because he accumulates many obligations at a time when he is least able to care for them.

Under the new plan the patient pays a little regularly while he earns. Then when he needs medical care, financial problems are no longer a factor. Nor are they a factor to the physician because the bill is paid promptly by Kansas Physicians' Service.

Social reformers attempt to compel the individual to protect himself against the cost of medical care. Unfortunately such programs also involve the doctor. That cannot be avoided for the deeper one probes this question the more complex the matter of equitably distributing medical care becomes. Fees, specialists, selection of doctors, hours of service are only a few of the problems that need solving. It is no wonder that the medical profession resents lay interference.

Arriving at a place where doctors could no longer merely stand by and object they prepared an answer. This has been accomplished in many states and has now become a fact in Kansas. The doctors' answer is simple. Let the patient decide if he wants to protect himself and his family; let participation be voluntary. Then let the doctor offer to

provide his service. Except for the manner in which fees are paid, why need anything about the patient-physician relationship be altered?

And that is how it stands. Under Kansas Physicians' Service the patient selects the doctor of his choice exactly as before and the doctor undertakes to treat his patient exactly as always. The fee to be charged, except for the lowest income group, is determined as at present—by the physician and the patient. So in the doctors' answer there is no essential change, while under a government-operated plan the medical profession would lose its identity. And the patient his individuality, as he would learn to his sorrow.

If this is socialized medicine, at least it is not state-operated. Initiated by the Kansas Medical Society, it has been organized and planned by the Society for its own protection and as a service to the public. If portions of the plan do not work out under experience, they can be changed by the Board of Directors. Contrast this with the delays that would accompany changes in a federally-operated program.

### Shawnee County Tea

The Auxiliary to the Shawnee County Medical Society entertained at a tea at the Topeka Woman's club on February 4 for the officers and representatives of several leading women's civic organizations in the city.

Dr. Barrett A. Nelson, Manhattan, president of Kansas Physicians' Service, spoke on the future of medical practice in Kansas. He discussed the pressure of various groups for the socialization of medicine, and stated that the profession agrees that there is need for better distribution of medical care and more equitable distribution of its cost. In answer to this problem the Kansas Medical Society presents its plan for voluntary pre-paid medical insurance, which Dr. Nelson explained in detail. A discussion period followed his talk.

### Meetings Over the State

Members of the Wilson County Medical Society and Auxiliary met December 28 at the Hotel Kelley for dinner, after which each group held a business session. Auxiliary officers for 1946 chosen at that meeting are as follows: president, Mrs. F. A. Moorhead, Neodesha; vice-president, Mrs. Raymond Beal, Fredonia; secretary-treasurer, Mrs. B. P. Smith, Neodesha.

\* \* \*

Forty members attended a luncheon meeting of the Wyandotte County Auxiliary at the home of Mrs. H. L. Regier on January 11. Officers of the Jackson County Auxiliary were guests of honor. Mrs. Maxene Nichols Bauers entertained with readings.

Mrs. E. R. Millis, chairman, was assisted by the following: Mesdames J. E. Barker, J. G. Evans, W. J. Feehan, E. J. Grosdidier, G. R. Hepler, H. W. King, A. W. Little, Merle Parrish, and P. J. O'Connell.

\* \* \*

Mrs. Dwight Lawson, assisted by Mesdames Leo Smith, Fred Mayes, G. A. Rogers, W. F. Abramson and Byron J. Ashley, entertained 33 members of the Shawnee County Auxiliary at a dessert-luncheon at her home January 7. Mrs. R. E. Pfuetze showed pictures of Puerto Rico.

A program of special interest is being planned for the annual meeting of the Woman's Auxiliary to the Kansas Medical Society. Every member who can attend should do so.

# Why Do People Use Cosmetics?



Isn't it because they wish to improve their appearance?

Why do people wish to improve their appearance? Isn't it because they have a natural desire to be as physically attractive as possible, both to satisfy their self-respect and to please those with whom they come in contact?

In the Federal Food, Drug, and Cosmetic Act, the term "cosmetic" is defined as, "(1) Articles intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for cleansing, beautifying, promoting attractiveness, or altering the appearance. . . ."

From this definition it is obvious that the chief functions of cosmetics are to cleanse and to improve the appearance, to beautify.

Cleanliness may be said to be the foundation of a lovely appearance. We are sure you will agree that the fundamental reason why people use cosmetics is to improve their appearance, to look lovelier.

It has been said that the function of a cosmetic is to encourage the normal physiology of the skin, not to change it. Cosmetics improve the appearance of the skin; they do not in our opinion change its physiology, which is to say its normal functioning, structure and individual characteristics.

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## BOOK REVIEWS

**PENICILLIN THERAPY (Including Tyrothricin and Other Antibiotic Therapy).** By John A. Kolmer, M.D., F.A.C.P. Published by D. Appleton-Century Company, 35 West 32nd Street, New York.

The rapid advances in penicillin therapy and other antibiotics have made it imperative that our knowledge of their limitations, methods and modes of administration, dosage and specific indications be systematized.

This book proceeds with a general discussion of penicillin: its production, assay, mechanism of action, toxicity, and pharmacology. Also noted, but less extensively, are other antibiotics, namely tyrothricin. Suggested therapeutic dosages and clinical management are indicated in the various diseases for which penicillin has been found effective. Adequate stress has been placed on the necessity for accurate laboratory tests to determine etiological agents of the disease and as to whether this drug is effective. Much emphasis is placed on the combined use of sulfonamides and penicillin.

Dr. Kolmer has presented the material in this book in the same authoritative manner that has characterized his previous books on laboratory and clinical diagnostic methods. The book is most excellent as it covers the subject of penicillin therapy, and it is to be recommended for student and practitioner as an authoritative summary of the present knowledge of this antibiotic.—*Dwight Lawson, M.D., Topeka, Kansas.*

\* \* \*

**MODERN PSYCHIATRY.** 1945 Edition. By William S. Sadler, M.D., F.A.P.A. Copyright 1945. 896 pages. Price \$10. Published by C. V. Mosby Company, St. Louis, Missouri.

This rather verbose book presents the author's point of view regarding the practice of psychiatry. It is written in textbook form and includes much that is now in the psychiatric field, such as the psychosomatic approach, the use of hypnotism in diagnosis and therapy, and the evaluation of the various shock therapies together with a rather comprehensive discussion of the various types of psychotherapy. The impression one obtains is that the book lacks sufficient objectivity to make it a valuable source of reference. It is easily read for it is couched in simple conversational language and is provided with a glossary for the benefit of those unfamiliar with psychiatric terminology. Unfortunately, factual information is so closely admixed with speculation and opinion that a reader not already familiar with the field of psychiatry would have difficulty in orienting himself properly.—*Henry H. Luster, M.D., Topeka, Kansas.*

\* \* \*

**AMERICAN RED CROSS FIRST AID TEXTBOOK.** Revised Edition. Prepared by the American Red Cross. 254 pages. Price, 60 cents with paper cover, \$1.00 with cloth cover.

The American Red Cross has issued a new edition of its first aid textbook which is largely revised from the previous edition. Now, as in all previous issues, the material has been written by doctors of medicine and has

been approved by a special committee on information. For those who are interested, the names of doctors, many of them well known to the entire profession, who have assisted in the preparation of this book are listed under special acknowledgement on Pages VII and VIII.

Upon first perusal the physician will consider that too much technical information is contained, that the course of instruction goes considerably beyond popularly conceived first aid measures. On second thought, however, it must be recalled that this textbook is used for classroom study under the supervision of a physician. Persons completing the course are expected to render services of a more technical nature than can be expected of others who have not completed the course. Moreover, in all courses of instruction students are consistently advised to render the more technical services only when a physician is not available and the need for those services is acute.

An example of the revisions contained in the new edition may be found in the recommendations of first aid treatment for burns. The old issue recommends the use of picric acid gauze, tannic acid and tannic acid jelly. The method of using these solutions is described in some detail. The new book suggests sterile petroleum ointment for burns of limited extent, and baking soda or epsom salts solutions for extensive burns, and advises that boric acid should never be used in first aid treatment nor should tannic acid be used on the hands or face. Other alterations could also be selected throughout the book.

The American Red Cross would appreciate having the medical profession examine this book and especially asks that a doctor in each locality be selected to serve as advisor to the Red Cross in the operation of first aid classes.

\* \* \*

**IN THE DOCTOR'S OFFICE.** By Esther Jane Parsons. Published by J. B. Lippincott Company, Philadelphia. 295 pages. Price \$2.00.

"The Art of Being a Medical Assistant," which is the sub-title of Esther Jane Parsons' book, "In the Doctor's Office," is very descriptive of the content.

Miss Parsons is very thorough with the detailed information in running an office to the best advantage. She has stimulated a broadening view-point on personality and politeness in dealing with the patient.

There are many ideas and suggestions that will be helpful to any phase of the office procedure. All of the material is very practical, and all receptionists, technicians and nurses in a doctor's office will find the time it takes to read it well spent.—*Mary Campbell, Topeka, Kansas*

## Books Received

**CARE OF THE AGED.** Fifth edition, revised. By Malford W. Thewlis, M.D. Published by the C. V. Mosby Company, 3207 Washington Boulevard, St. Louis. 467 pages. Price \$8.00.

**MEN WITHOUT GUNS.** Text by DeWitt Mackenzie, captions by Major Clarence Worden, foreword by Major General Norman T. Kirk. Published by the Blakiston Company, 1012 Walnut Street, Philadelphia. 152 pages, 177 drawings. Price \$5.00.

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Volume XLVII

MARCH, 1946

Number 3

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**KARTAGENER'S TRIAD. SITUS INVERSUS, ABSENT FRONTAL SINUSES WITH MAXILLARY ETHMOID AND SPHENOID INFECTION, AND BRONCHIECTASIS**

Mahlon H. Delp, Lt. Colonel, M.C. A.U.S.

General interest in this unusual clinical picture dates to a report of five such cases by Adams and Churchill<sup>1</sup> in 1937. Theirs was the first article in the English language describing this syndrome. Credit for the original description goes to Siwert<sup>2</sup> in 1904. Subsequently Kartagener<sup>3 4 5</sup> made a thorough study of the subject and published several articles, resulting in his name being attached to the triad. Kartagener in all has reported 11 cases. Olsen<sup>6</sup> with observation on 14 cases seen at the Mayo Clinic reviewed the literature and was able to find 31 cases reported. His additional 14 cases brought the total to 45. Richards<sup>7</sup> has added one more case of recent date. Other case reports have been made by Orei<sup>8</sup>; Guenther<sup>9</sup>; and Nussel and Hellbach<sup>10</sup>.

The infrequency of the syndrome in addition to the importance of continued search for the etiology and pathogenesis of bronchiectasis, we believe justify a single case being reported.

**CASE REPORT**

**PRESENT ILLNESS:** This 22-year-old white male entered the hospital because of a compound fracture of the left femur incurred in a transportation accident. The signs and symptoms bearing upon the present discussion, while incidentally brought out during his hospitalization, were well known to the patient. At the age of six, while in a fight, the patient was knocked down striking his head upon a piece of slate. This produced a laceration of the scalp resulting in profuse bleeding and unconsciousness. The physician summoned listened to his heart, and hearing no audible heart tones, pronounced the patient dead. Shortly after the patient regained consciousness, and when the physician checked his original findings, it was determined that the patient's heart was on the right side of his chest. The patient and his family were apprised of this fact at that time. Again at the age of 12, another physician examined the patient and upon discovering the dextrocardia suggested to the family that he perhaps had a complete transposition of all viscera.

As long as the patient can remember he has had a chronic cough. On frequent occasions he has coughed up a small amount of heavy purulent sputum. This cough is usually worse at night and early in the morning. He notices that smoking definitely aggravates the cough. The largest amount of material ever coughed up during any 24-hour period has been about four ounces. The patient has actually worried very little about the cough, but in 1940 consulted a physician because of a mild exacerbation of symptoms. On this occasion an x-ray was taken and the diagnosis of dextrocardia was confirmed. Sputum and blood examinations at that time were negative.

In 1942 the patient developed pneumonia. The diagnosis was confirmed by x-ray examination of the chest, and further confirmation of the dextrocardia was made. An electrocardiographic tracing was taken at this time and was said to be characteristic of dextrocardia. The pneumonia was mild, and the patient soon returned to normal activity. In November of 1942 the patient was inducted into the Army. His initial examination revealed the dextrocardia and for the first time a complete situs inversus was established.

Following hospitalization because of fractured femur, the patient was treated with traction and application of cast. There was nothing unusual in his convalescence and the findings of situs inversus, absent frontal sinuses, infected sinuses, and bronchiectasis were developed in routine study.

**SYSTEM REVIEW:** Eye, ear and throat negative. Cardio-vascular—For several years prior to entrance into the Army the patient had noticed mild shortness of breath. This had never been a serious disability. Gastro-Intestinal—No symptoms. Genito-Urinary—No significant symptoms. The patient had noticed that the right testicle was positioned lower than the left. Central Nervous System—No significant symptoms. Skeletal—The patient had known for at least four year that his fingernails were

more curved than those of the average person. Habits—No significant alteration from the average.

**PHYSICAL EXAMINATION:** Eyes and ears normal. Nose—Muco purulent discharge from either side of the nose, polyp within the left nares. Throat—Tonsils were small and not diseased. Heart—The apex beat was visible and palpable in the mid-clavicular line just medial to the right nipple in the fifth interspace. No thrust or thrill was felt. The sounds were normal in rate, rhythm and force. No murmurs were heard. The heart percussed normal in size and outline. It was transposed to the right. Liver dullness was normal but transposed to the left. Blood pressure 118/84, pulse rate 72. Chest—Well developed and normal in configuration. Expansion was equal. No palpable rubs or change in tactile fremitus. Slight impairment in percussion note in both lung bases posteriorly. Occasional sibilant rales could be heard anywhere in the chest, but these were not constant. In the posterior lung bases, small crepitant rales were audible. These persisted posttussively. Genito-Urinary—External genitalia normal except that the right testicle was positioned about  $\frac{1}{2}$  inch lower than the left. Extremities—Grossly normal but evidencing moderate clubbing of the fingers. Flexion of the left knee was mildly limited, and there was a large well healed scar on the lateral surface of the left thigh.

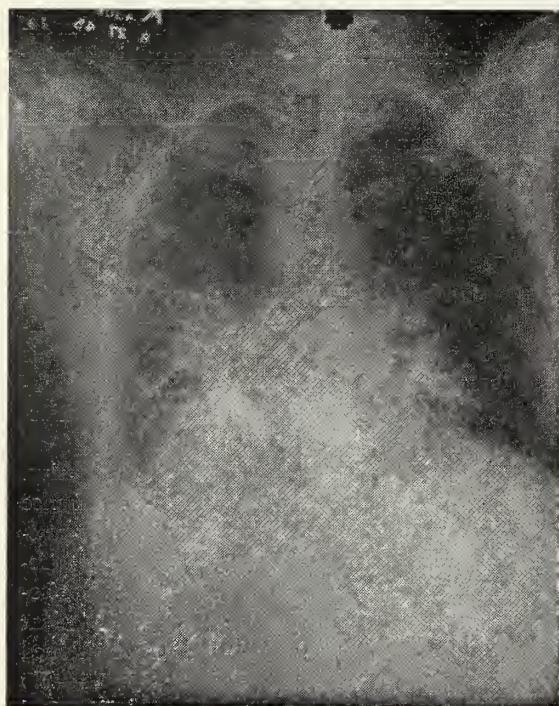
**LABORATORY REPORTS:** Routine examination of the blood including WBC, RBC, differential and hemoglobin within normal limits. Blood serology negative. Urine examination negative. Re-

peated sputum examinations were negative. The maximum quantity of sputum for any 24-hour period was 30 cc's. X-ray examination of the chest: The right diaphragmatic dome and costa phrenic angle were obliterated by old healed pleurisy. There was a partially obscured underlying mottling which had the appearance of bronchiectasis. Dextracardia was present. The CT ratio was normal. Bronchograms showed a complete situs inversus of pulmonary structure, the anatomical structure being normally developed except for transposition. There was a moderate degree of mixed type bronchiectasis; saccular and cylindrical, of right and left lower lobes. These findings were more prominent on the right. The bronchiectasis on the left was chiefly cylindrical. There was moderate thickening of the patient's pleura on the patient's right. A barium enema showed complete transposition of the colon with no evidence of organic disease. X-ray examination of the stomach, esophagus and duodenum was normal in every respect except for transposition. The relationship to other transposed structures was normal. Five-hour retention films showed no gastric retention. The liver shadow appeared on the left.

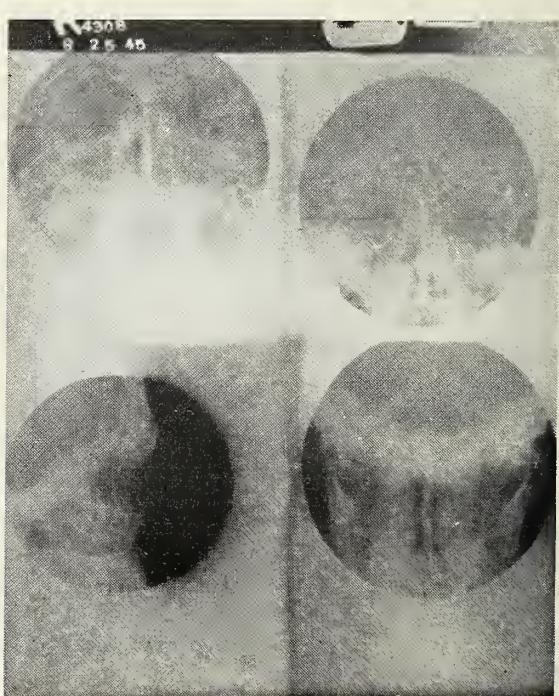
**PROGRESS IN HOSPITAL:** This patient made an uneventful recovery from his fracture of the femur and was discharged from the hospital, with advice and direction for conservative management of his sinusitis and bronchiectasis.

#### DISCUSSION

There has long been lack of agreement as to



A. Dextracardia and bronchial dilatation.



B. Absent frontal sinuses with infection of remaining sinuses.

etiology and pathogenesis of bronchiectasis. Two schools of thought regarding the problem have arisen. One has contended that bronchiectasis is congenital in origin while the other has favored an acquired background. It seems likely both theories are correct. Accurate figures as to the true incidence of bronchiectasis in large groups are not available. Surveys of great cross sections of the population by means of routine lipiodol installations hardly seem practicable, but it would offer one means of determining the true incidence of bronchial dilatation and dry bronchiectasis not now available. Olsen<sup>6</sup> has emphasized the fact that many persons with bronchial dilatation are entirely symptom free. He has aptly pointed out that the commonly described symptoms of bronchiectasis are in reality, "those of its complications; namely, infection of ectatic bronchi."

Those investigators favoring the theory that bronchiectasis is an acquired disease point to the work of Adams and Escudero<sup>11</sup> who have called attention to the importance of obstruction in the development of bronchiectasis. Holinger<sup>12</sup> has shown clearly that bronchial stenosis can be an etiological factor. Andrus<sup>13</sup> has forwarded the opinion that atelectasis is of great etiological importance. Anspach<sup>14</sup> has as well pointed out that post pneumonic atelectasis may be a forerunner of bronchiectasis in some cases.

The remarkable incidence of bronchiectasis in the presence of other congenital anomalies such as absence of frontal sinuses and complete visceral trans-

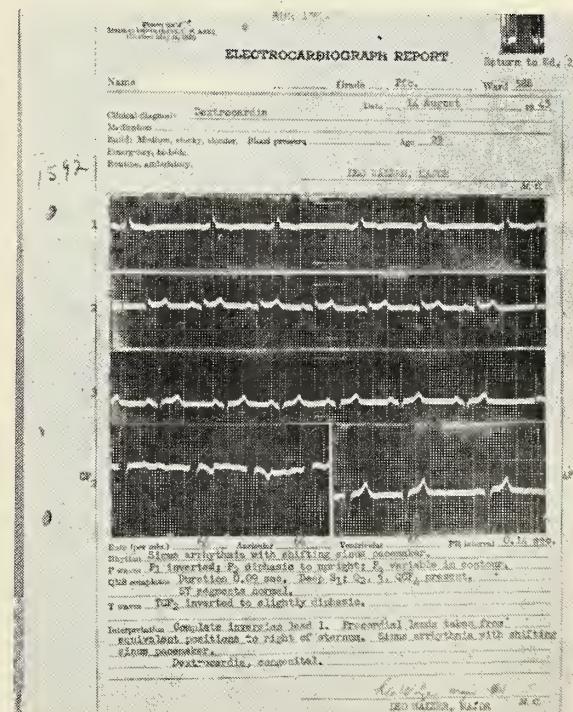
position has seemed to indicate a likewise congenital origin for the bronchial dilatation. This seems true at least in the group under discussion. Kartagener and Harlacher<sup>5</sup> estimated that in their group 20 per cent of the cases of dextracardia also had bronchiectasis. Adams and Churchill<sup>1</sup> reviewing the cases at Massachusetts General Hospital for the period 1886-1934 found five cases of situs inversus with bronchiectasis and diseased accessory sinuses. Since there were 23 cases of situs inversus recorded during this same period, this represented an incidence of 21.7 per cent filling the qualifications for Kartagener's Triad. The incidence of bronchiectasis in the entire group hospitalized for the like period was 0.306 per cent. Olsen<sup>6</sup> found 14 (16.5 per cent) of 85 patients with congenital dextracardia admitted to the Mayo Clinic over a 22-year period to have bronchiectasis. He likewise found a low, less than  $\frac{1}{2}$  of 1 per cent, incidence of bronchiectasis in the general registration for this given time. There is still another congenital anomaly, namely "fibro-cystic disease of the pancreas," described by Kennedy and Baggemos<sup>15</sup> which is almost invariably associated with extensive bronchial dilatation. These reports have lent considerable force to the argument that at least a great many cases of bronchiectasis have a congenital origin and come to light with the development of symptoms at a late date.

#### SUMMARY

1. A case evidencing situs inversus, absence of frontal sinuses, infected paranasal sinuses, and bron-



C. Transposition of colon.



D. Electrocardiogram characteristic of dextracardia.

chiectasis, (Kartagener's Triad) has been presented.

2. A brief review of the literature reveals that 46 similar cases have previously been reported.

3. The high incidence of bronchiectasis associated with situs inversus and abnormalities of the paranasal sinuses increases the importance of congenital mal-development as an etiological factor.

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## THE USE OF CURARE AS AN ADJUVANT FOR THE IMPROVEMENT OF MUSCULAR RELAXATION

**Paul H. Lorhan, M.D.\***

Mission, Kansas

The dream of every anesthesiologist is that he might be able to produce rapid and complete muscular relaxation in the resistant patient under a general anesthetic. For even under the most favorable conditions and with every anesthetic agent, occasion does arise when it is next to impossible to obtain sufficient relaxation for the satisfactory performance of upper abdominal operations and to close a friable peritoneum. Surgical manipulations are always facilitated by a state of complete muscular relaxation, quiet breathing and a contracted intestine. If this state can be obtained by the addition of a nerve paralyzing drug during anesthesia, without increasing the hazard to the patient and without predisposing that patient to undesirable postanesthetic sequelae, the administration of such an agent becomes desirable if not used to supplant good anesthesia by careful administration of the anesthetic agent.

It is admitted that ether in sufficient dosage will produce adequate muscular relaxation; but this is only accomplished by decreasing the maximum safety for the patient. The amount of ether that is necessary to produce relaxation will affect the patient adversely by the production of acidosis and glycosuria. In addition during surgical anesthesia, a "rocking boat" motion is elicited due to over accentuation of the diaphragmatic movements so that the intestines are difficult to confine to the abdominal cavity. When such a depressed state is necessary for surgical anesthesia it will extend over into the postanesthetic period and recovery will be prolonged. This is then followed by excessive nausea and emesis, urinary retention, abdominal distention and a marked predisposition towards various pulmonary complications.

Cyclopropane alone in major abdominal proced-

ures will produce a quiet abdomen and contraction of the intestine; but it is impossible to produce adequate muscular relaxation in the majority of patients unless ether is added to the mixture or a high concentration of cyclopropane is used. Prolonged high concentration of cyclopropane will produce cardiac irregularities in the patient and postanesthetic hypotension.

Nitrous-oxide plus oxygen in itself is insufficient to produce adequate muscular relaxation for intra-abdominal procedures unless it is accompanied by asphyxia or complemented with spinal block.

The intravenous barbiturates (pentothal sodium and evipal sodium) are not recommended by competent anesthesiologists for intra-abdominal procedures unless they are complemented by a gaseous anesthetic.

Spinal anesthetics will produce the ideal working conditions for the surgeon in intra-abdominal operations, when they are given by experienced personnel. However, during long operations the patient becomes uncomfortable from remaining in the same position and the constant presence of pressure and traction of the mesentery. Therefore, spinal anesthesia is frequently supplemented with an inhalation anesthetic.

The anesthesiologist of today is constantly endeavoring to provide the surgeon the maximum

Table No. 1 Age of Distribution	
10-19	3
20-29	3
30-39	11
40-49	9
50-59	13
60-69	11
70-79	7
	—
Youngest	16
Oldest	75

\* Department of Anesthesia, University of Kansas Hospitals, Kansas City, Kansas.

conditions of muscular relaxation, contracted intestine and a quiet abdomen so that he can work more closely under the ideal conditions necessary for good intra-abdominal surgery.

In an effort to obtain this ideal condition curare has been used during general anesthesia in the resistant patient. The effects of curare as a nerve paralyzing drug have been known to the pharmacologist for a long time. It has also been used by the clinician in the treatment of various spastic disorders and convulsive states such as tetany, strychnine poisoning and chorea and since 1938 it has been found useful by neurologists in controlling the frequency of fractures accompanying the convulsions of metrazol shock therapy. The anesthesiologist first began to use it in 1942 in the resistant patient during a general anesthetic.

The pharmacological effects were first described by Claude Bernard in 1865<sup>1</sup> as acting on the neuromuscular junction. In 1936, Brown and Feldberg<sup>2</sup> demonstrated that the drug interfered with the transmission of impulses across sympathetic ganglia.

The action of curare is specific in that it interferes with the transmission of impulses across the sympathetic ganglia by blocking of the responses to the nicotinic action of acetylcholine. It not only prevents the effector substance of voluntary muscles from reacting to acetylcholine but also prevents the synaptic transmission between preganglionic and postganglionic fibers of the sympathetic division of the autonomic nervous system.

The action of curare is selective in nature, and its intravenous administration in man results in immediate effects. First, there is a feeling of heaviness of the eyelids, followed by bilateral ptosis, strabismus and diplopia. The neck muscles soon become affected and the patient is unable to raise his head, the speech is slow and the throat and jaw muscles then become flaccid. The spinal muscles are then involved and lastly there occurs complete paralysis of the arms, legs and abdominal muscles. The muscles of respiration are involved late with the diaphragm being the last muscle affected. Smooth muscles are not affected. Nor is there any direct effect on the heart or the peripheral circulation. Cardiac

failure results from the anoxia following the respiratory arrest and not from a direct toxic action of curare on the heart. Consciousness and sensibility are retained to the end.

Curare is partly destroyed by the liver and the remainder eliminated unchanged by the kidneys. In the presence of a markedly impaired renal function the drug may become quite toxic.

Curare is administered intravenously or intramuscularly. When given by the former route its effects are noted within two to three minutes. Intramuscularly its effects are observed within 20 minutes. Its paralytic action lasts for 20 to 30 minutes. Overdosage will cause a respiratory paralysis from which recovery is complete if artificial ventilation of the lungs is maintained.

Curare has now been used at the university in 57 surgical patients undergoing major intra-abdominal procedures and in a few selected cases in patients in whom bronchoscopy or suspension laryngoscopy was to be done. (Table 1)

The following procedure is used: Premedication the same as in all patients who are to receive a general anesthetic, with the exception that atropine is slightly increased if curare is to be used. The induction and maintenance of anesthesia is carried out by the carbon dioxide absorption technic. Curare is administered at the time the surgeon makes his incision in only those patients whom the anesthesiologist deems it is necessary and in whom he suspects that he is not going to obtain adequate muscular relaxation.

Curare is always administered intravenously, the initial dosage being 40 to 60 mgm. At the end of three to five minutes if adequate relaxation and contraction of the intestine are not observed an addi-

Table No. 4  
Types of Operations

Supravaginal hysterectomy .....	3
Anastomosis of hepatic duct to duodenum .....	1
Appendectomy .....	3
Excision vocal cord tumor .....	1
Bronchoscopy .....	2
Resection of sigmoid, with end to end anastomosis .....	1
Ovarian cystectomy, myomectomy, appendectomy .....	1
Cholecystectomy .....	9
Cholecystectomy with choledochostomy .....	5
Drainage abdominal abscess, closure of colostomy .....	1
Mikulicz operation for ca of colon .....	1
Splenectomy .....	1
Gastroenterostomy with cholecystectomy .....	1
Exploratory laparotomy with biopsy .....	3
Salpingoophorectomy with uterine suspension .....	1
Posterior gastroenterostomy .....	4
Gastric resection gastroenterostomy .....	3
Partial gastrectomy, resection of proximal portion of duodenum, anterior, gastroenterostomy .....	1
Duodenojejunostomy .....	1
Salpingectomy with excision of fistulous opening in abdomen .....	1
Cholecystectomy and appendectomy .....	2
Supravaginal hysterectomy with bilat. salpingoophorectomy .....	1
Uterine suspension with resection of ovary .....	1
Loop colostomy .....	1
Combined abdominal perineal resection for ca of rectum .....	1
Cauterization with salpingectomy .....	1
Cholecystogastrostomy .....	1
Closure of perforated duodenal ulcer .....	1
Suspension laryngoscopy .....	1
Repair rectal prolapse with fascial transplant .....	1
Exploratory laparatomy with removal of mass from around common duct .....	1
Excision adenoma of pancreas .....	1

Table No. 2  
Dosage Used

20 mgm. ....	10
40 mgm. ....	19
50 mgm. ....	2
60 mgm. ....	12
70 mgm. ....	6
80 mgm. ....	5
90 mgm. ....	2
100 mgm. ....	1

Table No. 3  
Anesthetic Used

1. C <sub>3</sub> H <sub>6</sub> .....	23
2. C <sub>3</sub> H <sub>6</sub> with Ether .....	12
3. N <sub>2</sub> O with Oxygen .....	6
4. N <sub>2</sub> O with Ether .....	4
5. Spinal .....	4
6. Spinal with C <sub>3</sub> H <sub>6</sub> .....	4
7. Pentothal .....	4

tional 20 mgm. is given. With this method the maximum state of quiescence and relaxation will be obtained within a few minutes; it is then maintained throughout the entire surgical procedure. At the time of closure of the peritoneum an additional 20 to 40 mgm. may be given if necessary to facilitate the closure of the abdomen. (Table 2)

With this technic marked respiratory depression was observed in only three of our patients so that it was necessary to maintain artificial respiration to ventilate the patients. This depression occurred in patients who had received ether at some time during the operation to produce relaxation. When ether is used the amount of curare used should be half of what one would expect to give when a gas anesthetic is used. (Tables 3 and 4)

Curare's usefulness in the field of otolaryngology has been adequately demonstrated in the few cases we have used it. Intravenous pentothal sodium was the agent of choice. The technic of administration differs from that with the gas anesthetic in this respect. Curare is given intravenously while the patient is awake until the patient's voice becomes deep and husky. To obtain this level requires 40 to 60 mgm. of curare. Intravenous pentothal is then given until the patient stops counting; which occurs when the patient has received three to five cc. of a 2.5 per cent solution. Additional amounts of pentothal are then given as required. With this technic

the amount of pentothal is decreased by approximately 50 per cent. Continuous oxygen is given to maintain adequate oxygenation. No alarming reactions have been noted in these patients and all were awake upon completion of the surgical procedure.

Postanesthetic complications were not observed in these patients which might be attributed to the action of curare.

In conclusion the action of curare to provide complete muscular relaxation, contract the intestine and a quiet abdomen has been of great assistance to the surgeon in doing major intra-abdominal procedures. The narrow margin between the most effective dose for relaxation and that which will produce respiratory depression need not be of great significance. However, it is essential that an expert in anesthesiology undertake the administration of this nerve paralyzing drug. It should not be used as an adjuvant to produce relaxation because of poor anesthesia. Curare's usefulness in surgery by an experienced anesthetist justifies its use in those patients in whom it is impossible to obtain sufficient relaxation by the gaseous anesthetic without the addition of toxic doses. Curare can and should only be used in conjunction with good anesthesia.

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#### Meeting Announcement

The Kansas Society of Obstetrics and Gynecology will hold a business meeting and election of officers following a luncheon on Wednesday, April 24, at Wichita, according to an announcement made recently by Dr. Howard C. Clark of Wichita, secretary of the organization. Since the annual session of the Kansas Medical Society will be held at Wichita April 22-25, this meeting was planned for a date during that week.

The Kansas Society of Obstetrics and Gynecology is one of the most active specialty organizations in the state of Kansas, and work has continued all through the war, in spite of physician shortages and the heavy work that has taken the time of each of its members. It is urged that everyone interested in this organization note the date and make plans to be present at the luncheon and business session.

#### Announcements

The executive board of the American Public Health Association announces the 74th annual meeting of the association to be held in Cleveland, Ohio, the week of November 11, 1946.

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A postgraduate course in diseases of the chest will be given under the auspices of the Illinois chapter of the American College of Chest Physicians at Michael Reese hospital, Chicago, during the week April 1 to April 6, inclusive. Further information may be secured from the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The American Association for the Study of Goiter will hold its annual meeting at the Drake hotel, Chicago, June 20, 21 and 22. Any member who wishes to read a paper at the meeting is asked to send the title to Dr. S. F. Haines, Mayo Clinic, Rochester, Minnesota, chairman of the program committee.

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The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. Complete information may be secured from Dr. James R. Bloss, secretary, 418 Eleventh Street, Huntington 1, West Virginia.

#### Philippine Journal Resumes Publication

A recent letter from the editor of the Journal of the Philippine Medical Association advises that publication of that monthly was resumed in January of this year. The last issue was printed in December, 1941, publication being suspended while the Japanese occupied the islands, so the enemy would not be able to make use of it for propaganda purposes.

The Journal of the Kansas Medical Society will exchange publications with the Philippine journal in response to their request, expressed in the following terms: "We beg you to place us again on your mailing list. And more, if you still have the back numbers of the Journal since January 1942 to spare, it would be our greatest joy if we could have them! We had been completely isolated from the scientific world during 1942-1944; and you can understand how thirsty we are for new medical knowledge."

# 87th ANNUAL SESSION

As final plans are made for the 87th annual session of the Kansas Medical Society, to be held at Wichita April 22-25, interest among members is reflected in the large number making plans to attend. A record attendance is anticipated, partially due to the fact that no scientific programs or social events were included last year under wartime restrictions and partially because of the outstanding specialists scheduled to appear on this year's program.

The annual session this year will be conducted along the lines of pre-war meetings. In addition to the general scientific section there will be a full program of interest to EENT specialists, the usual meetings of the House of Delegates, round table luncheons with guest speakers to discuss topics of specialized interest, a golf tournament, and numerous social events. The annual banquet will be a feature on Wednesday, April 24.

Members of the Woman's Auxiliary to the Kansas Medical Society will gather for their own sessions, as outlined on the tentative program published in the Auxiliary section of this issue. Similarly, members of the Kansas Medical Assistants' Society will hold a two-day session on April 21 and 22 and will hear speakers on topics of interest to all those employed in doctors' offices.

A copy of the complete program will be mailed soon to all members of the Society and will be printed in the April issue of the Journal. However, the names of a number of speakers are being announced early so that physicians throughout the state will know the specialists to whom they will be privileged to listen.

A large number of exhibits, both scientific and technical, will engage the attention of doctors between sessions. A number of county societies, individuals and state institutions are preparing scientific displays, and interest in this section indicates a more impressive exhibit than has ever before been presented.

Advance reservations for space for technical exhibits have been arriving at the executive office daily since announcements of the meeting were mailed. Many exhibitors will be present at the Kansas meeting for the first time, and all of the old familiar companies will again be represented. Doctors will be welcome visitors at the booths, and each company will have its representatives on hand to discuss details of new and old products. These commercial exhibitors were keenly disappointed last year when the streamlined meeting precluded their attendance, and they promise exhibits of unusual interest for this session.

All publicity about this session has stressed the importance of early reservations for hotel rooms, and reports from Wichita indicate that many have already made arrangements for accommodations. It appears that a sufficient number of rooms will be available, but those who plan to attend are urged to write immediately to the hotel of their choice, the Lassen, the Allis or the Broadview, to secure confirmation. Anyone who is unsuccessful in making reservations can receive assistance from the committee in charge in Wichita by writing Mr. Martin Baker, secretary of the Sedgwick County Medical Society, Schweiter Building, Wichita 2, Kansas.

## ANNUAL SESSION KANSAS MEDICAL SOCIETY April 22-25, 1946

### SPECIAL GUEST SPEAKERS

**Major General Paul R. Hawley**, chief medical director, Veterans' Administration  
**Colonel James C. Harding**, in charge of out-patient care, Veterans' Administration

Outstanding specialists will take part in the scientific program, speaking on medicine, surgery, and all the specialties. Confirmations have been received from the following:

#### MEDICINE

**A. C. Ivy, Ph.D., M.D.** Head of the Department of Physiology at Northwestern Medical School, managing editor of Gastroenterology, chairman of the Board of Publications Trustees of the American Physiological Society, member of the National Advisory Cancer Council and the Baruch Committee on Physical Medicine.

**Wallace E. Herrell, M.D., M.S.** Assistant professor of medicine, Mayo Foundation; consultant in medicine, Mayo Clinic. Fellow of the American College of Physicians and a member of the Central Society for Clinical Research, American Federation for Clinical Research, the American Therapeutic Society.

**Lowell D. Snorf, M.D.** Associate professor of medicine, Northwestern university, chief of department of medicine, Evanston hospital, member American College of Physicians, diplomate of Internal Medicine, member of American Gastroenterologic association.

#### PEDIATRICS

**Mitchell I. Rubin, M.D.** Professor of pediatrics, University of Buffalo, and pediatrician-in-chief, Children's Hospital of Buffalo. Formerly associate professor of clinical pediatrics, University of Pennsylvania.

#### ORTHOPEDICS

**Walter Cleveland, M.D.** Attending orthopedic surgeon, St. Luke's Hospital, New York City; consulting orthopedist, Beekman Hospital, North Country Community Hospital, Glen Cove, L. I., Henry W. Putnam Hospital, Bennington, Vermont, Nassau Hospital, Nassau, L. I.

#### EENT

**Francis L. Lederer, B.S., M.D.** Professor and head of Department of Laryngology, Rhinology, and Otology, University of Illinois College of Medicine. Member American College of Surgeons, American Academy of Ophthalmology and Otolaryngology, American College of Chest Physicians.

## PRESIDENT'S PAGE

### TO THE MEMBERS OF THE KANSAS MEDICAL SOCIETY:

I am glad to report that all of the details of the agreement between the Veterans' Administration and the Kansas Medical Society have been completed. We have been held up, as you know, for the past several weeks because of the hospital contract and the securing of personnel to handle the office. This latter difficulty has been solved, but there is to be a training period of a few weeks at the Veterans' Administration in Wichita before the individual selected to head the office is sent to Topeka. We expect this to be accomplished within the next three weeks. The office space has been secured; the furniture has been shipped; and we hope to have the office in operation by the first of April. We will have the names of all of the men who have signed up approved within the next week and, just as soon as personnel arrives, we will open the office. You will be informed of the date of opening through newspaper publicity.

We have added laboratory procedures to our contract with the Veterans' Administration and, when this is completed, we will send a copy to you.

The American Medical Association, through the Council of Medical Service and Public Relations, has decided to establish a national prepayment program for medical care of the American people. This program will be set up in such a manner as to coordinate it with our Kansas Physicians' Service. By doing this, we will be able to take care of employees of national organizations who reside in our state. This will undoubtedly be a great step forward.

We sincerely hope that you will make a special effort to attend the annual meeting of the Kansas Medical Society, which will be held in Wichita from April 22 to 25, 1946. The program committee has promised an excellent program, and we also have the promise of General Paul D. Hawley of the Veterans' Administration and his first assistant, Colonel Harding, to be with us and to participate in our program. We expect the majority of the men who have returned from service to be there. We should make a special effort to coordinate a great many of the activities of the Society at this meeting.



W.W. Peacock, M.D.  
President

## EDITORIALS

### How Things Get Done

The term "Organized Medicine" from both a scientific and from a sociological standpoint is a gross misnomer.

We might pause just a moment to review the history of organized medicine. In the earlier days the only particular bond between physicians was the oath of Hippocrates and the fact that all were engaged in the healing art. Certain groups were bound together in a loose sort of way by having studied under the great physicians of the past.

As time went on, some of the original thinkers began to realize that, if disease and pestilence were to be conquered, some type of organized effort must be made. So a few individuals, each having his own following, went about the business of organizing medicine from a scientific point of view.

It was under this banner that our own great American Medical Association was organized. No one can question the giant strides which have been made in the scientific fields of medicine and the healing arts. Consider the great organizations devoted to medical research and the great medical centers devoted to treatment of patients and to the teaching of medical personnel. Are these the results of the action of individuals? No. They are the results of concerted action of individuals and groups of individuals with the common purpose in mind to produce in America the finest in medicine.

By lay education amongst the thinking groups of other professions and businesses, funds have been raised through both private enterprise and public monies to support these institutions. During the medical life span of our older members, most of the financial support of medical research has come from private endowment.

In recent times organized medicine has protected or tried to protect the public in many ways. Hospitals have been standardized through the efforts of the American College of Surgeons. Medical schools have been graded and standardized and diploma mills have become almost extinct through the efforts of the Council on Medical Education and Hospitals. Drugs have been standardized and their sale regulated through the efforts of the Council on Pharmacy and Chemistry. Physicians have been classified by virtue of the examinations of the varying specialty boards. Information concerning new and modern discoveries has been disseminated to the members of the profession by medical publications and through medical meetings, including national, sectional, state, county and individual hospital meetings.

Have you ever stopped for just a few minutes to think what all of these things mean to you as individual practitioners of medicine? Would you like to be practicing medicine where there were no standardized hospitals? Have you done your share in the past? Are you going to do your share in the future?

We, as practitioners of medicine, face one of the most critical periods in our existence. We have responded as a group very well indeed to the scientific problems which have confronted us. I have no doubt that we will continue to make scientific advances. However, we have certainly been tardy if not absent altogether in our sociological problems.

As individuals, we have been too prone to criticize the policies of the A.M.A. in legislative and other matters without knowing what these policies are, and without knowing first what they are doing about it. It is easy for us to sit back and let "Harry and John" do the work and then put them on the "sizzling platter" because their plans or results are not to our liking.

Well! What are we going to do about it? Are we going to permit the public to get their education in matters medical from the leaders of labor or industry? Are we going to enter an era of political control where some clerk on a forty-hour week can hold up a dose of morphine for a patient who needs relief of pain because it is after five o'clock?

Now is the time to begin to do our share. In all probability this very month your county medical society will hold a meeting. If it does not have a meeting, it should. What is the purpose of this meeting? First, it is a medium for meeting your fellow doctors on an equal basis. Second, it is a meeting for the dissemination of medical information. Third, it is a meeting where the problems facing organized medicine can be studied and discussed, thereby laying the cornerstone or at least a few of the bricks in the foundation of the future of medicine. Are you willing to do your share?

Next week the staff of your hospital will have a conference. Will you be there? It will be worth your while if you want to make it so. Will your paper to the staff presenting an unusual or interesting case history be purely a recitation of a few clinical details, or will you look up the literature and present a discussion which will not only be of value to the staff but a greater value to yourself?

In April the Kansas Medical Society will meet in Wichita. This is the first full-fledged meeting since 1942. You know the reason why. However, it is a very important meeting. There are changes taking place in the sociology of medicine. Many of our doctors who have been gone for three or more years are going to be there. Some of them are going to think that they haven't had a square deal. Some of

them haven't. Are you going to be there? Are you a member of a committee that has an important job? Are you willing to do your share?

In July the A.M.A. will meet in San Francisco. It will not be possible for us all to attend. However, we will have representation. Are our delegates going to San Francisco uninstructed?

It is time for us to take inventory. Some of us haven't done so for so many years that we have a lot of out-dated and worthless stock on our shelves. It is high time that we shake loose from the idea that we are individual physicians with a chosen clientele of private patients. That day is gone. We cannot be isolationists in the practice of medicine. We as individuals are the integral building stones of medical practice and education in all of its many phases. It is our duty to take care of all of the people of this country efficiently and economically. If we do so, socialized medicine will never come.

In the original premise the statement was made that the term organized medicine is a gross misnomer. The term can only be used when and if there is complete harmony and integrity of purpose between the parent organization, the component organizations and the individual members. Then, and only then, can we literally use the term organized medicine. There is an old adage which states, "A chain is no stronger than its weakest link." You are a link. Is your link strong enough to be woven in the mat of organized medicine?

### Blue Cross Looks Toward The Future

Kansas Blue Cross, in three years of operation, has wheeled once around a circle and now pauses to ponder its future. Upon the inauguration of Kansas Physicians' Service the medical society has elected to cast its lot with the fortunes of Blue Cross, so from this moment becomes more vitally concerned with its problems than ever before.

This circle is a curious example of scattered and devious forces reacting upon the ideals of an organization that aims at public service. Blue Cross, it will be recalled, began as a means for prorating the cost of hospital care. After intensive publicity, the people of Kansas began to approve of the program until now enrollment has reached 175,000. But people are inclined to use benefits they pay for so hospital admissions increased. As hospitals fill with patients, new hospitals must be built or the public must be instructed to use hospitals less frequently. If neither of those situations can be controlled, general unhappiness exists. This is especially true when service has been paid for in advance.

A similar equation can be constructed from another perspective. Unless voluntary plans prosper,

compulsory participation will probably result. The voluntary plan must be attractive or it will not be purchased. In this instance that implies that the public must consider Blue Cross a good investment. However, actuarial data cannot be ignored if the organization is to exist and at once the problem is seen from its monetary angle.

Today the subscriber pays \$18 a year for Blue Cross protection. He and his family are entitled to hospital care when needed. As long as previous averages existed the figure was sound, but strange things are happening to statistics at present. In 1944, 99 out of every 1,000 members were hospitalized. During 1945 the rate rose to 110. Indications during the early months of 1946 are that this admission rate is continuing to rise.

Certainly no single factor is alone responsible. The public has been taught that hospital care aids in more rapid recovery from illness. After investing in the project, the individual considers himself entitled to its use. The medical profession has favored the program because a hospitalized patient can more easily be controlled. Nor has the Hospital Association exerted efforts to alter this trend.

Upon the completion of three years' enrollment, Blue Cross faces a dilemma. Subscribers are joining at an ever-accelerating pace and expenses continue to increase. As the second circle of activity begins, officials and the Subscribers' Council agree that a solution needs to be found. Increasing the rate is dangerous from a public relations standpoint. Building additional hospitals is not necessarily a sound economic solution. Reducing benefits raises suspicion.

So while the Blue Cross considers its prospects, Kansas Physicians' Service stands by reflecting on the problem. The solution may well rest with the medical profession in the last analysis, and for that reason discussion of this problem is recommended and suggestions are invited.

### Cancer Control—April

Several diseases have become crusade issues. Lay organizations spread propaganda on prevention or cure and plead to the public for contributions. Cancer, however, is almost singular in this regard because the national lay organization for the control of cancer is directed largely by a board of physicians. Activities in the American Cancer Society are carefully defined so that the lay public is active only along lines of education and the raising of money.

Education as conducted by the Field Army stresses diagnosis and early treatment by doctors of medicine. During the 40 years that the American Cancer Society has been in existence, and the ten that

the Field Army has operated, there has been no deviation from these principles.

During April a more intensive campaign will be conducted than ever before. For almost the first time in Kansas, men will assist women in its operation. Mr. Laird Dean of Topeka has accepted the responsibility of leading this campaign and began several months before the opening date to organize all counties in the state.

The Field Army now issues an appeal to the medical profession in Kansas for assistance. Of primary importance is the selection of a speakers' bureau in each county of the state. The Field Army hopes that all speakers will be doctors of medicine since no lay person can adequately discuss the subject.

The Kansas Medical Society urgently requests the assistance of all members in this undertaking because the deeply concerned lay public looks to the profession for leadership.

### The A. F. of L. Speaks

The 19th annual meeting of the National Conference on Medical Service was held in Chicago on Sunday, February 10. During the all-day session many speakers were presented, but one in particular will be mentioned because of the contrast he presented from opinions expressed by all other speakers.

Mr. Nelson P. Cruikshank, director of Social Security activities of the American Federation of Labor, spoke on "What Labor Expects of Medicine." His presentation carried with it the philosophy that would be expected from a person in his position. It was, however, an opportunity to hear from an official of labor who spoke with the assurance that the people he represented would support his views.

Mr. Cruikshank appealed to the doctors in the audience to listen on the basis that in America free speech is permissible. It is possible that in this search for truth labor may be wrong, but it is equally possible that medicine is wrong, he said.

Health is important to the worker because it underlies his security. As far as the A. F. of L. is concerned, modern medical care is desired, but a way is sought to eliminate the present catastrophe that frequently arises when illness strikes. Labor thinks that extensive protection under compulsory insurance is the only way the problem can be solved.

The speaker said that labor respects medicine for its scientific advancements but has a very low opinion of medicine's economic approach. Scientific knowledge is to be left entirely to the profession, but the economics of medicine represent a two-party affair of which labor is a large portion of the second party. In those matters the patient has a right to speak.

Labor is familiar with existing voluntary prepaid

plans but dismisses them with the statement that voluntary systems will never solve the problem because there are too many exclusions and because too few participate.

As might be expected, the speaker drew from statistics to establish his statement that the people in the United States are not receiving the type of medical care that they should have. No explanation or apology was given his figures that regarding infant mortality the United States is in eighth place among the nations of this world, that regarding mortality among children this nation is twelfth, and that regarding mortality in middle life this nation is twenty-first. He stated these as facts and concluded thereafter that medical care under a socialized system would raise these standards.

The Wagner-Murray-Dingell bill, from the words of this labor leader, was not only entirely endorsed by the A. F. of L. but also in large part written upon the suggestions of this group. Moreover, the Pepper bill was also authored, if his statements were correct, by his labor organization. The A. F. of L. has money and the organization to press for passage of these measures. Meetings are being held throughout the United States and official labor publications are carrying messages to support such action. The speaker closed by saying, "We can replace words with action. I implore your assistance."

Just as the Journal goes to press a telegram is received from the American Medical Association declaring that the Senate Committee on Education and Labor has scheduled hearings on the Wagner-Murray-Dingell bill to commence on Tuesday, April 2. Hearings are expected to run for about a month. And then it will all be over. The situation on April 2 or shortly thereafter will depend largely on what has been accomplished by the medical profession within that time.

### Refresher Course March 25-29

The program for this month's refresher course at the University of Kansas School of Medicine, one of a series being held under the auspices of the Division of Graduate Medical Education of the school, the Kansas State Board of Health, and the Kansas Medical Society, has been announced. Postgraduate work will be offered in internal medicine, psychiatry and dermatology in a four-day period, March 25-29 inclusive. A copy of the program will be sent on requests addressed to the University Extension Division, University of Kansas, Lawrence.

In addition to members of the University faculty, the following guest instructors will take part: Gen. William C. Menninger, M.C., Washington, D.C.; Dr. Harold H. Jones, Winfield; Lt. Col. Mahlon H. Delp, M.C., Cleveland, Ohio; and Dr. Harry L. Alexander, St. Louis, Missouri.

The University Extension Division also announces general plans for the April program, a refresher course for graduate nurses. The dates have been set for April 23-25.

# Councilor Reports

*The following reports of activities in the twelve councilor districts of the Kansas Medical Society during the past year are presented in this issue, a month before the time of the state meeting, to give members of the House of Delegates an opportunity to study the work of the year before the House convenes.*

## FIRST DISTRICT

To the House of Delegates:

Two district meetings were held during the year, one at Atchison the latter part of June and the other at Sabetha in August. Dr. Lattimore and Mr. Ebel, the guest speakers at each meeting, gave us an excellent discussion of the problem confronting the doctors of Kansas at present. Both were dinner meetings and were well attended by the doctors and their wives from every county in the district. We wish to thank the members of the Atchison and Nemaha County Medical Societies for their splendid cooperation in arranging for these meetings. We feel that the doctors of the First District are very alert to the many problems confronting medicine at present.

Respectfully submitted,  
R. T. Nichols, M.D., Councilor.

## SECOND DISTRICT

To the House of Delegates:

Because of the seemingly ever-increasing load upon the members of our profession, attendance at meetings away from one's immediate locality has been extremely difficult.

A meeting of representatives of the several county societies comprising the Second District was held in Kansas City, January 5, for the purpose of explaining the contract of the Kansas Medical Society with the Veterans' Administration.

The officers of the Kansas Medical Society are to be congratulated upon their forward-looking program to increase the scope of adequate medical care for the veteran.

Respectfully submitted,  
Lewis G. Allen, M.D., Councilor.

## THIRD DISTRICT

To the House of Delegates:

I herewith submit this report which is intended to summarize the activities of the councilor for the Third District during the past year.

One of the first problems attacked was the raising of funds for the Kansas Postgraduate School. An attempt was made to canvass the entire Third District by personal letters to each doctor together with and by the appointment of special assistants in each county who, by the way, responded magnificently, yet in the final analysis and in spite of all the effort put forth for such an excellent cause, the end results were somewhat embarrassing; the conclusions were to the effect that there still remained a deficit in, and of consideration for others. At this point, I would highly recommend a resolution for this year; whereby all of us will improve our philanthropic relations and therefore gain greater cohesion for the society in general.

I was privileged to be a member of the Committee on Postgraduate Study and this committee has functioned by meetings with Dr. Hashinger, who was appointed Dean of the Graduate School. With Dr. Hashinger's cooperation, I feel that definite progress has been and is being made.

Your councilor has served on the Vocational Rehabilitation Committee and this program is now under way and the results are in evidence almost daily. The clinic that was held in the district was very well supported by the profession and in this connection I wish to again extend thanks and appreciation for all who participated and helped make the clinic the success that it was.

The Kansas Physicians' Service plan is now being instituted throughout the state. The program and plan are being very well received throughout the Third District, and here again considerable credit is due many men who have actively participated in the preliminary work, and no doubt as this service becomes more widely used, the benefits will be more quickly accepted.

As is now common information, the final steps are being taken to complete the details for an entirely different plan of caring for the veterans under certain conditions. It is my sincere hope that these plans which have required considerable time as well as expense in completing, will be of benefit to all the members of the Society. The perpetuation will depend on the actions of each and every participating physician.

There has been a rather steady flow of men from service and it is a pleasure to note in our area that they have been able to quickly readjust themselves to civilian work. I believe I share the feeling of all the men who have been making every effort possible to carry on during their absence that it has been a real relief in having the men return home, and I am sure that it is the sincere wish that each and every one who has been in service will and can quickly compensate himself for the time he has been away. There are several locations in the Third District which I feel are most inviting to men willing and wishing to do general practice. I hope these vacancies can in the near future be properly satisfied.

The activities of your councilor during the last year have, as you can surmise from the above, varied widely. Numerous council meetings as well as various committee meetings have been called and attended. At times great effort was expended in fulfilling these requirements, but your councilor wishes to advise that the time and money involved were gladly given and the only reward expected is that these efforts will not be in vain, but in the final analysis find that these efforts brought about and helped to produce a closer fraternal relationship, and therefore benefits will be experienced by each and every man within the district.

Respectfully submitted,  
C. H. Benage, M.D., Councilor.

## FOURTH DISTRICT

To the House of Delegates:

As councilor for this district I have attended several meetings out of which came the Kansas Physicians' Service and the Veterans' Administration agreement. I have not had time to have any district meetings. The Lyon County Society has met regularly with good attendance. All but two of the physicians in service from Emporia and surrounding territory have returned which has relieved the pressure on the men who were not in the service. Doctor Hunter of Lebo and Doctor Neinstedt of Hartford have both returned. Neither of these towns had any medical service while they were gone and there are many other towns without doctors which could support a physician if they could be induced to locate there.

I am much in favor of the Blue Cross but feel that

possibly they are overselling the hospital space available. Undoubtedly most hospitals will have to have additions and have them soon. This will mean the voting of bonds in many instances, in which case it will be up to the physicians to get the public interested and encourage them to initiate the drive. I feel that if the laymen take the lead in these things they will be more apt to be successful in carrying a bond issue than if the physicians themselves take the lead.

Respectfully submitted,

F. Foncannon, M.D., *Councilor.*

#### **FIFTH DISTRICT**

To the House of Delegates:

The Fifth Councilor District of the Kansas Medical Society is proud of its record in World War II, both in number of doctors in military and naval service and their individual service records.

We are most happy to welcome a goodly number back into regular practice and hope before long those still serving may be relieved.

To those who have returned, let me remind you that the Kansas Medical Society is your society. Get into its activities. The local county society needs your advice and help.

The Fifth Councilor District has been cooperative in the many plans inaugurated by our state organization during the past year, especially the following:

1. The postgraduate courses.
2. Kansas Physicians' Service.
3. State society provision for financial assistance for veteran doctors.
4. State society cooperation in National Physicians' and Hospital Service.
5. Veterans' care and hospitalization by home physicians.

The wisdom and benefit of such plans will meet the test of trial during the next years.

Your councilor has endeavored to represent you in our district in a fair and impartial way at the numerous meetings. My regret is that during the past unsettled years personal contacts have been much too few.

Respectfully submitted,

John L. Grove, M.D., *Councilor.*

#### **SIXTH DISTRICT**

To the House of Delegates:

We are glad to announce that a large number of our members who have been missing on account of service in the armed forces have already returned and others are soon to return so that our membership will soon be back to nearly normal.

The various component societies have been fairly active during the last year in spite of war conditions and absent members. This is particularly true of Butler, Sedgwick and Cowley counties. Considerable work has been done throughout the district on preparations for the Veterans' Administration contract and the matter of Kansas Physicians' Service.

The regular Sixth District meeting was held in Wichita, January 13, 1946, with approximately 150 members present at which time Dr. W. P. Callahan, our state president, thoroughly discussed the need of the Veterans' Administration.

Respectfully submitted,

Warren F. Bernstorf, M.D., *Councilor.*

#### **SEVENTH DISTRICT**

To the House of Delegates:

Again I shall try to make a report on matters of interest pertaining to the North Central Kansas area or Seventh District. As your councilor of this district I wish to state that in my opinion medical conditions are generally speaking satisfactory. Most of the county societies are quite active, holding meetings more or less regularly, some of the scientific meetings being given by outside talent.

Due to the Kansas Veterans' Administration program it has been necessary that I visit several of the county societies in an effort to give them information relative to this program. I have recently visited Concordia where Cloud and Republic county members attended, with one member from Clay county present. I also visited Clay Center where members of Clay and Washington counties were present. I more recently made a trip to Beloit where I met the physicians of Jewell and Mitchell counties. Naturally I have held meetings here in Manhattan for the Riley county members concerning this program. These meetings were all quite well attended and the general plan, though new and slightly confusing, has been generally speaking very well accepted. Most of the members speak quite favorably of the general plan, and I believe there will be little misunderstanding or difficulty after it once becomes operative.

At the July meeting of the Golden Belt Medical Society, which was held in Manhattan, an attempt was made to get the members of the Seventh District here for attendance since it was considered there were matters of sufficient importance to justify this effort. At that meeting the president of our Kansas Medical Society, Dr. W. P. Callahan, gave a splendid talk. Mr. Oliver Ebel, our executive secretary, called several things to the attention of those present. County Medical Society representatives and their wives were guests of the Riley County Medical Society for dinner.

A brief summary of the individual counties follows:

Clay county has 14 physicians now in active practice. Their hospital facilities are excellent and consist of the Clay Center Municipal hospital, which proposes a new addition of 20 beds in the next six or nine months. Clay county is very active and has regular monthly scientific meetings, a few of which are by outside medical talent. All in all, they have very fine programs. Dr. J. L. Lattimore, Topeka, was guest speaker on one occasion and was very well received. They have 100 per cent membership in their county.

There are 22 physicians in Cloud county with about 95 per cent membership in the county medical society, which holds scientific meetings three or four times a year. One physician in the county, Dr. A. M. Townsdin of Jamestown, retired during the past year because of poor health, and one physician, Dr. L. E. Filkin, who practiced in Junction City before entering military service, has moved to the county. All members in military service have returned to their practices. There are two hospitals in Concordia, and the St. Joseph hospital there is planning a new 100-bed addition.

Jewell county has seven physicians. They have had one death, Dr. J. W. Yankey of Esbon. The county does not have hospital facilities, and apparently none are contemplated at present. Usually the physicians hold few meetings during the year, but occasionally attend at Beloit or Concordia. They have five physicians who belong to their society and two non-members in the county.

Mitchell county has 10 physicians. They have had no deaths or retirements. They have ample hospital

facilities, in fact a splendid hospital of 55 beds at Beloit, and they are contemplating a larger one. They hold regular monthly scientific meetings, and at approximately six of their meetings they have a guest speaker. The other meetings are addressed by local talent. There are nine physicians who belong to the society and one who does not.

Republic county has seven physicians. They have lost two by retirement or death, Dr. T. W. West of Narka and Dr. F. C. Tyree of Agenda. Their hospital facilities consist of the Patterson Memorial hospital at Belleville, which is adequate. Their meetings are fairly regular although one is missed occasionally.

Riley county has 20 physicians. One physician, Dr. J. D. Colt, Sr., who had been extremely active in local, district and state medical society matters, retired this year. At one time he was president of the Kansas Medical Society, and he has been a bulwark in matters pertaining to medicine in the district for more than 20 years. He had been active up to the time of his retirement, and although we hate to see him discontinue his practice we are happy that he can retire in good health. We sincerely wish him a grand and glorious vacation from a previous life of hard work. The hospital facilities in Riley county consist of St. Mary's hospital and Parkview hospital, both in Manhattan. The total capacity is 106 beds, and we find this inadequate with at least another 125 beds needed to take care of demands properly. We hope that by some means we may succeed in obtaining additional space for patients in the near future. Membership is 100 per cent.

Washington county has seven physicians. It does not have a hospital at present, but at a recent election a motion was carried for a 40-bed hospital to be built soon, and taxes are already being levied for that purpose, which is a hopeful sign. Even during the war with their small membership of five, the county had monthly scientific meetings except during the summer. Five of the seven physicians are now members of the society and two are not. There will shortly be an addition of two physicians in the county.

Respectfully submitted,  
R. R. Cave, M.D., *Councilor.*

#### EIGHTH DISTRICT

To the House of Delegates:

Two very important events have happened to the Kansas Medical Society during the past year. I believe they are both healthy for the organization. One is the placing in operation of Kansas Physicians' Service and the other the inauguration of the Veterans' Administration and Kansas Medical Society program.

The immense amount of work put forth by the Kansas Physicians Service Committee and our president, Dr. W. P. Callahan, relative to the V.A. program is truly commendable. I sat in numerous councilor meetings and marveled at the energy and patience these men displayed.

I called a meeting of the members of the Kansas Medical Society in my councilor district at Salina, Kansas, January 15, 1946, for the purpose of discussing the V.A. program. I gave to those present what information I had gathered and explained the program to them. The meeting was fairly well attended.

I also sent a refresher letter to each of the presidents of the societies in the eighth district January 21, 1946, urging them to have all of their members send in their names and expressions regarding the classification of each,

as a specialist or general examiner, for the V.A. program, as soon as possible. This list of names has been sent to the central office in Topeka, Kansas.

The meetings of the medical societies in the eighth district have been held regularly. They were well attended and had good programs.

I attended all councilor meetings but one.

Respectfully submitted,  
B. H. Mayer, M.D., *Councilor.*

#### NINTH DISTRICT

To the House of Delegates:

I believe that a greater interest in the activities of the Kansas Medical Society has been evidenced in the Ninth District during the past year. All meetings have been well attended.

The slowing down effects of time and the inroads of the grim reaper have been somewhat counter-balanced during the last few months by the addition of four doctors to our territory. Dr. Carl E. Sixbury has located at Oberlin, in the practice of eye, ear, nose and throat. Dr. Sixbury served a number of months in the Southern Pacific area. Dr. John C. Conroy, an overseas veteran with 21 months' service with the 35th Infantry, has opened an office at Atwood. Dr. W. W. McDougal, who served in France and Germany with the 96th Evacuation Hospital, is now located at Colby. Dr. Murray E. Robinson is associated with Dr. M. J. Renner in Goodland. Dr. Robinson was on active duty in the Southern Pacific for more than two years.

The various programs and activities of the state society have been very well received by the doctors of this district.

Respectfully submitted,  
Haddon Peck, M.D., *Councilor.*

#### TENTH DISTRICT

To the House of Delegates:

In submitting my report, I wish first to thank the central office and the members in my district for the kindness and courtesy extended to me the past year.

Again the grim reaper has visited our locality and taken with him our colleague, Dr. P. S. Brady. This makes five in two years in the Tenth District.

Meetings have continued, papers were improved and attendance increased. I believe there is a feeling of urgency among the profession to acquire all the knowledge obtainable after a period of hard work and little opportunity to leave home.

Respectfully submitted,  
Otto A. Hennerich, M.D., *Councilor.*

#### ELEVENTH DISTRICT

To the House of Delegates:

As councilor of the Eleventh District I respectfully submit the following report:

The demands on the doctors of this district during the past year have been quite heavy due to absence of many of our doctors in service and the added work from our Army air bases.

Due to the fact that everyone was busy, our county societies have been inactive the past year.

On the whole the sick of this district have been quite adequately cared for.

Pratt hopes to have a new eighty-bed hospital within the next year if sufficient building material is available.

Respectfully submitted,  
J. R. Campbell, M.D., *Councilor.*

## TWELFTH DISTRICT

To the House of Delegates:

As councilor of the Twelfth District I wish to make the following report of activities in this district.

As of the present date almost all of our doctors have returned from the service, the greater part of whom have returned to their former locations and will soon be in active practice as before. In other parts of the state we have been very short of doctors. I would like to take this opportunity to welcome the returning veterans and I feel that we should make everything as co-operative as we can to make their practice a success. However, Dr. G. Kenneth Lewis has informed us that he expects to join a group in Chicago where he will limit his practice to plastic surgery, for which he is well qualified. We wish him well in his new location.

We have made several attempts to have councilor meetings but only succeeded in one which was held in Garden City on the fifth day of February. This meeting was very well attended and a good program was presented of which the scientific part was given by Dr. John L. Lattimore on the Rh factor. His talk was very much appreciated.

Following this, Mr. Oliver E. Ebel discussed the Kansas Physicians' Service plan and the Veterans' Adminis-

tration agreement. Both of these programs were well received and freely discussed and all comments made were favorable.

We would like to take this opportunity to express our appreciation of the good work which has been done by our president, Dr. W. P. Callahan, and to the Veterans' Administration and to Dr. Barrett Nelson on the very thorough job he has done with the Physicians' Service plan. We feel that these are the two most outstanding things that have been well started during the past year. No doubt they will have a great influence on the practice of medicine in the state of Kansas, as well as the whole United States, in future years.

The Farm Security program was voted out at this meeting which has been carried on since the days of the depression. We felt that this program had served a useful function in the past but has outlived its usefulness and time for termination had arrived. This district, as is well known, has been very short of doctors and hospital facilities. However, there has been one hundred thousand dollars donated to Grant County to be used for the erection of a county hospital in Ulysses as soon as materials can be obtained at a reasonable cost.

Respectfully submitted,  
G. R. Hastings, M.D., Councilor.

## Committee Reports

*The following reports from chairmen of the various committees of the Kansas Medical Society summarize the important activities of each group during the past year.*

### ALLIED GROUPS

J. E. Henshall, Chr., Osborne; J. D. Colt, Jr., Manhattan; Irl E. Hempstead, Hutchinson; A. E. Hiebert, Wichita; George E. Milbank, Wichita; Leo A. Smith, Topeka; William L. Speer, Osawatomie.

To the House of Delegates:

This committee has not had a meeting in the past year because no problem arose that appeared urgent enough to call the members together. Individually and in behalf of the committee various members have done considerable work with allied groups.

A speaker was provided the Kansas Dental Association on subjects of Federal legislation and means to combat the passage of undesirable bills. This led to conferences following which the dental profession is preparing to set up programs within its own group similar to those in operation in the Kansas Medical Society.

Close co-operation between the Kansas State Nurses' Association and the Kansas Medical Society has continued to exist by reason of Dr. J. F. Hassig's presence on that board.

At present the Kansas Conference of Social Work is preparing its program. On the program committee are four persons representing the Kansas Medical Society who are arranging the session on health for this meeting. The most important individual meeting of this conference will be an evening program open to the public on health. The speaker is to be provided by the doctors on this committee.

Respectfully submitted,  
J. E. Henshall, M.D., Chairman.

### AUXILIARY

C. Omer West, Chr., Kansas City; W. Y. Herrick, Wakeeney; Hugh A. Hope, Hunter; E. J. Nodurft, Wichita; W. L. Pratt, Leavenworth; H. H. Woods, Topeka.

To the House of Delegates:

The annual report of the Auxiliary Advisory Committee is a most happy one this year.

There has been a splendid response in organized membership and a special effort has been made in obtaining members at large. There has also been a marked increase in interest in the Bulletin, and it has also enjoyed an increase in subscriptions. Hygeia is reaching new heights in its rapid spread over the state of Kansas.

The Program and Public Relations chairmen have coordinated their work during the past year on health education, legislation, juvenile delinquency, cancer control and Red Cross. These programs have been most successful in reaching lay club groups. This will be of marked advantage to organized medicine.

The chairman of Legislation has made a special effort this year to get information in the hands of the Auxiliary in order that they might be well informed on all legislative matters pertaining to organized medicine.

A nice gesture has been made by some county medical societies by paying the dues of not only their absent members while in the war effort but have also paid the dues of the Auxiliary members to the state and national organizations.

It has been a privilege to work with Mrs. Hugh Hope as president of the Auxiliary, who has given untiringly of her time to the work during the year.

Respectfully submitted,  
C. Omer West, M.D., Chairman.

### CHILD WELFARE

E. G. Padfield, Chr., Salina; Paul E. Belknap, Topeka; Paul R. Ensign, Topeka; C. T. Hinshaw, Wichita; D. N. Medearis, Kansas City; F. L. Menehan, Wichita.

To the House of Delegates:

Your committee on Child Welfare did not have a meeting during the past year.

There are some changes in the E.M.I.C. plan in the wind but until the Academy has decided upon it, it does not appear that we should attempt to go into the study of it. Certainly the health of the children of the nation could be taken care of better than is being done, but until the hospital survey is completed and something is done for the isolated communities to get better medical

attention, we had better mark time. The children's section of the Kansas State Board of Health should be commended for the excellent work it is doing in the field of immunization.

Respectfully submitted,  
E. G. Padfield, M.D., *Chairman.*

#### **CONSERVATION OF EYESIGHT**

W. W. Reed, Chr.; Topeka; J. A. Billingsley, Kansas City; W. G. Gillett, Wichita; J. G. Janney, Dodge City; L. A. Latimer, Alexander; J. S. Reifsneider, Wichita; E. N. Robertson, Concordia; Dale D. Vermillion, Goodland.

To the House of Delegates:

The Conservation of Eyesight Committee has held one meeting during the year, January 6, 1946, with Mr. Ebel and four members present.

The appointment of a state supervising ophthalmologist to succeed the present incumbent was discussed and the name of Dr. B. J. Ashley was recommended for consideration. A suggestion was made that the term of office for that position be for two (2) years instead of eighteen (18) months. This was approved by the members present.

The sales tax problem as expressed by the optometrists was discussed, and no action was taken.

The committee was entirely in accord and agreed to support any recommendations from the Public Relations Committee.

The matter of industrial health as related to eyesight was also discussed, but no definite recommendations were made.

Later the committee met with the director of the Division of Services for the Blind of the state Social Welfare Department and his staff, at which time several questions pertaining to present policies were discussed, and a recommendation was made that the program be broadened in some respects, particularly with regard to squint cases, at least giving them an adequate refraction and surgery when indicated.

Respectfully submitted,  
W. W. Reed, M.D., *Chairman.*

#### **CONSERVATION OF HEARING**

L. B. Spake, Chr., Kansas City; T. D. Blasdell, Parsons; E. D. Carter, Wichita; J. H. Enns, Newton; P. A. Pettit, Paola; C. T. Ralls, Winfield; W. A. Smiley, Junction City; Karl W. Stock, Topeka.

To the House of Delegates:

The committee has found it difficult to have a meeting but is planning to convene during the week of the state meeting in Wichita. The primary purpose is to enlist the aid of the medical society in the establishment of a clinic for the impairment of hearing cases at the University Hospitals. Plans are being prepared which will be submitted to the committee for the formation of such a clinic, which it is hoped will be of benefit to the whole state of Kansas.

Respectfully submitted,  
L. B. Spake, M.D., *Chairman.*

#### **CONSTITUTION AND RULES**

A. W. Fegely, Chr., Wichita; A. C. Dingus, Yates Center; H. E. Haskins, Kingman; George I. Thacher, Waterville; J. L. Wentworth, Arkansas City.

To the House of Delegates:

Your committee offers several Constitution and By-laws amendments for your consideration.

Under existing rulings the Society is exempt from income tax, but the question arises that future changes in the personnel of Washington officials might possibly cause a less liberal interpretation of certain sections of our Constitution and By-laws, thereby withdrawing the

present exemption under Section 101-(7) of the Internal Revenue Code, which would automatically not only render the Society liable for income tax but would also exclude the right of individual physicians to list dues and fees paid to the Society as deductible from income tax. After consultation with the attorney, Mr. Dale, the discussion was condensed and presented to the officers, councilors and members of this committee for opinions. Replies were meager, but realizing the possible future importance of these matters the chairman has chosen to present certain changes for discussion and vote. These proposed changes are presented below as they appeared when printed for the first time in the February, 1946, issue of the Journal of the Kansas Medical Society.

#### **1. Constitution, Article II—Purposes of the Society.**

Line 7 which now reads, "To secure the enactment and enforcement of just medical laws" shall be amended by eliminating the compulsory and emphatic word "secure," which might be interpreted as influencing legislation, and substituting the advisory word "advocate," making this portion of the Article read, "To advocate the enactment and enforcement of just medical laws."

#### **2. By-laws, Chapter V—House of Delegates—Section 12.**

This section which now reads, "It shall consider and advise as to the material interests of the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto" shall be amended to read, "It shall consider and advise as to the material interests of the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall advocate all proper medical and health legislation and the diffusion of popular information in relation thereto."

#### **3. By-laws, Chapter XI—Committees—Section 24.**

This section now reads, "The committee on Public Policy shall consist of at least three members and in addition the president-elect and the secretary. Under the direction of the House of Delegates and the Council it shall represent this Society in securing and enforcing legislation in the interest of public health, scientific medicine and the medical profession. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people and shall strive to organize professional influence so as to promote the general good of the community in local, state and national affairs and elections. At least one member of this committee shall have served on the retiring committee."

This section shall be amended to read, "The committee on Public Policy shall consist of at least three members and in addition the president-elect and the secretary. Under the direction of the House of Delegates and the Council it shall represent this Society by keeping in touch with professional and public opinion and advocate legislation to secure the best medical results for the whole people and promote the general good of the community in local, state and national affairs and elections. At least one member of this committee shall have served on the retiring committee."

#### **4. By-laws, Chapter XI—Committees.**

Section I shall be amended by the addition of "The Committee on Expert Testimony" to the existing standing committees.

#### **5. By-laws, Chapter XI—Committees.**

This section shall be amended by the addition of a new Section 30 to read as follows: "The Committee on Expert

Testimony shall be composed of at least five members of which at least three shall have served on the retiring committee and all members shall be chosen from various sections of the state. By virtue of appointment on this committee, members should avoid serving as expert witnesses in medical matters.

"It shall be the duty of this committee to investigate, analyze and review medical testimony given in any civil, criminal, or personal injury case brought before any of the courts of this state, the industrial commission or Federal Courts when such testimony appears to the court, any of the attorneys, some physicians or any of the principals of the case at issue to have been contradictory, not justified by the physical findings, or one or more of the medical witnesses have consciously deviated from the truth.

"In general their procedure shall be as follows: Upon receipt of a signed written statement from judge, attorney, accusing physician or individual giving names of principals appearing in the trial court or commission in which held and some detail of the alleged improper testimony together with the name of the physician whose testimony is to be investigated, they shall be empowered to secure a transcript of the entire case in question for examination and review. Bill for necessary costs of securing the transcript shall be certified to the Council for payment from Society funds.

"When examination of the transcript by the committee shows merit in the accusation, the committee shall refer the matter to three physicians admittedly expert in the particular type of testimony under consideration for their review with recommendations to the committee. The name of the individual signing the complaint shall not be attached to the papers for review but shall be confidential to the members of the committee only. When review of the case finds the complaint justified one or more of the members of this committee shall discuss its findings with the accused physician, pointing out delinquencies, errors, overenthusiasm, or infractions from proper medical testimony in order to avoid or prevent continuance of such practices. In cases of flagrant character or of belligerency on the part of the offending physician this committee shall be empowered to submit a complete report with transcript to the State Board of Medical Registration and Examination for disciplinary action.

"When evidence points to the possibility of an attorney acting in collusion with an offending physician the committee shall be privileged to present its review of the case to a committee of the Bar Association which may be delegated to consider the ethics of the offending attorney."

\* \* \*

These proposed amendments are to be printed in the Journal and presented for discussion at the first meeting of the House of Delegates and voted upon at the last meeting of the 1946 session as outlined in By-laws, Chapter XV-Amendments.

Respectfully submitted,  
A. W. Fegly, M.D., Chairman.

#### CONTROL OF CANCER

C. C. Nesselrode, Chr., Kansas City; L. G. Allen, Kansas City; J. P. Berger, Wichita; C. D. Blake, Hays; J. D. Clark, Wichita; Howard Snyder, Winfield; Karl E. Voldeng, Wellington; John Porter, Concordia; C. A. Hellwig, Wichita; N. E. Melencamp, Dodge City; J. B. Nanninga, Newton; H. S. O'Donnell, Ellsworth; M. Trueheart, Sterling.

To the House of Delegates:

This committee held meetings throughout the year. For the most part they have been well attended and your chairman believes that considerable progress in cancer

control has been made as a result of the interest shown by the medical profession in Kansas.

During the past year the American Cancer Society has been in the throes of reorganization. The personnel of this organization was enlarged to include the entire United States. The new program suggested by the American Cancer Society will also call for an expanded campaign which it is confidently believed will result in the donation of more money than ever before. The American Cancer Society has set up a program on three points. The first of these is research, to be conducted on a national scale from money obtained by the various states. The second is service, by which is meant offering assistance, financial and professional, on local levels for supplying the public with a uniformly high degree of medical care. The third, education, has largely been under the direction of the Field Army.

This year following the recommendation of this committee the Field Army is being enlarged to receive the assistance of men who will co-operate with the women, thereby expanding the splendid work that has been accomplished in the past.

It would be impossible to pay tribute to Mrs. Daisy Johnntz in words for the services she has rendered as state commander of the Field Army. She and the women from all counties of the state who have served voluntarily have done a splendid job that is entirely worthy of support by the medical profession. This year Mr. Laird Dean of Topeka has accepted the chairmanship for the campaign, which assures Kansas a high measure of success.

During the past year the Kansas State Board of Health organized a Division for the Control of Cancer, as authorized by the last state legislature. The organization of this division has proceeded according to suggestions from the Committee on the Control of Cancer.

During the past year all county societies were requested to plan the organization of detection clinics for cancer. The committee spent considerable time discussing this subject and concluded that three types of clinics could be established according to resources available in the various communities. In each county there could be a detection clinic, operated by the county society. The public would be invited to visit the clinic for examination without charge. Should lesions be discovered, the patient would be sent to the family physician for further examination and treatment. Detection clinics shall be staffed by members of the society serving without fee.

Areas more highly populated and with additional facilities might set up diagnostic clinics. These clinics would be equipped to make biopsies and reach more specific diagnoses than would be attempted by detection clinics. Again they would be operated under the direction of the county society and manned by a staff elected from the society as a whole.

The third type is known as a treatment center. This is presumed to be a fairly elaborate organization meeting standards of qualification required by the American College of Surgeons and the American Medical Association to diagnose and treat cancer.

Any society is invited to consult with this committee for further information. Clinics of any type may be established by any society providing the minimum standards can be complied with. If the committee is able to offer assistance at any time, inquiries are welcomed.

The Committee on the Control of Cancer is preparing a graduate clinic on cancer to be presented at six centers over the state during the early spring. A prominent speaker will appear and official notification will be sent

out later. This project is being conducted in co-operation with the Committee on Postgraduate Education.

Your chairman has several matters of business which he would like to discuss before the House of Delegates, and begs permission to present a supplementary report at the time of the annual session.

Respectfully submitted,  
C. C. Nesselrode, M.D., *Chairman.*

#### CONTROL OF TUBERCULOSIS

Galen M. Tice, Chr., Kansas City; A. L. Ashmore, Wichita; Kellogg F. Bascom, Manhattan; Ralph I. Canuteson, Lawrence; Clay E. Coburn, Kansas City; Albert A. Gausz, Leavenworth; H. L. Hiebert, Topeka; C. H. Letrigo, Topeka; Eugene D. Liddy, Jr., Lawrence; George Marshall, Colby; Henry P. Palmer, Scott City; Karl M. Rottluff, Bonner Springs; Ralph Y. Strohm, Fort Scott; C. F. Taylor, Norton; F. A. Trump, Ottawa; J. B. Ungles, Satanta.

To the House of Delegates:

A meeting was held by the committee this year with eleven members and five visitors present. Dr. Hiebert, who has been quite active through the state in tuberculosis case finding work with the photo fluorographic units, reported on his work. Members of the committee who have been in contact with this work were enthusiastic over the results. It was stressed by several that the procedure applies not only to school children but their contacts.

Dr. Taylor reported on the work of the Hillcrest project in Topeka. Up to the time of the meeting, 60 patients had been accepted in this institution for diagnosis. Dr. Wahl, dean of the Kansas University Medical School, expressed the opinion that there should be available at least 100 beds for the care and study of tuberculosis on the University Medical School campus. He recommended that in addition to cases of pulmonary tuberculosis there should be cases available for study of complications in the intestinal tract, joints and genito urinary tract.

Some criticism was expressed of the patient who has been found to have tuberculosis but who would not voluntarily absent himself from the society of others. Dr. Taylor said that it is within the province of the health officer to forcibly quarantine this individual in his home or sanitarium for whatever time he feels is necessary. The health officer has the backing of Kansas state law in this procedure.

A motion was passed by the committee to ask the Veterans' Administration to set aside a building at Winter General hospital for the treatment of tuberculosis.

Respectfully submitted,  
G. M. Tice, M.D., *Chairman.*

#### EXPERT TESTIMONY

C. E. Joss, Chr.; L. G. Allen, Kansas City; C. R. Rombold, Wichita; J. W. Spearling, Columbus; E. M. Sutton, Salina.

To the House of Delegates:

The committee on Expert Testimony has utilized this year in attempting to formulate definite plans regarding methods of operation. We are submitting as a report of this committee a document explaining the procedures to be adopted. We respectfully request authority to order reprints to be distributed to the jurists of Kansas, to the attorneys and to the Kansas State Bar Association.

As a service to the jurists of this state, to the Kansas State Bar Association, and to the public at large, the Kansas Medical Society has appointed an Expert Testimony Committee. We hereby respectfully offer the benefit of professional medical opinion to assist in establishing the scientific accuracy of medical testimony.

The Kansas Medical Society believes that testimony by doctors of medicine in Kansas has been accurate, scientifically sound and offered without prejudice. This situa-

tion would undoubtedly continue regardless of the existence of an Expert Testimony Committee so its services will only rarely be required for the purpose of exploring dishonest statements.

Increasing use of medical testimony by the courts has given the expert witness a broader responsibility than before. Correctly performed, his services are of great value in establishing an equitable solution, but when medical testimony lacks accuracy the interference with justice is proportionately as important.

It is readily recognized that inaccurate testimony is not generally the result of a deliberate attempt to falsify facts. More frequently is it attributable to inexperience, over-enthusiasm, fear, or lack of information on specific subjects. The Expert Testimony Committee will serve to correct these situations where they arise and will stimulate a uniformly high degree of accuracy in all medical testimony.

The Kansas Medical Society is of the opinion that no physician has right to practice medicine just as he pleases, nor to testify in court in a similar fashion. We believe that a physician's testimony should be based upon a factual background that has been carefully scrutinized by the physician before he expresses his opinion. Under those circumstances the opinion is of value to courts and juries alike. The scrutiny required is all the greater where the defendant is on trial for murder and the history of any physical or mental abnormalities is furnished by the defendant or someone close to him.

Next to saving life and giving aid to the sick and injured no greater responsibility devolves on the medical profession than giving unbiased truthful testimony in court or elsewhere. The right of a physician to continue in the practice of medicine is measured not only by his professional competence as a physician but also by what he says in his professional capacity.

#### OPERATION OF COMMITTEE

1. The Expert Testimony Committee is appointed by the president of the Kansas Medical Society subject to approval by the Council. Members are selected on the basis of geographical location and to obtain representatives in various medical specialties.
2. The judge or attorney or accusing physician must submit in writing a brief statement to the committee, giving the name of the physician to be investigated and also the names of the principals in the trial, in order that a transcript of the entire testimony may be obtained.
3. The committee shall have at its disposal the entire testimony of the case in question so it may receive the true facts and arrive at an unbiased and just opinion.
4. The Kansas Medical Society shall pay the cost of obtaining transcripts of such testimony, if such transcript is not otherwise available.
5. When any particular type of testimony is under consideration, not less than three physicians, admittedly expert in that field, will be requested to review the testimony and report their findings to this committee.
6. The attorney for the Kansas Medical Society will assist by ruling on matters bearing on legal points.
7. Names of physicians whose testimony is being investigated shall be kept confidential.
8. The Expert Testimony Committee has no disciplinary or judiciary authority. Where testimony is mildly questionable, the committee will advise with the physician under consideration in an effort to inform him of acceptable procedure. Flagrant cases will be reported to the Kansas State Board of Medical Registration and Examination where formal action of suspension or revocation may be instituted.

9. The Expert Testimony Committee invites the Kansas State Bar Association to appoint a committee of its members to co-operate in this project. Where evidence points toward collusion between an attorney and a physician for the purpose of falsifying medical testimony, this evidence will be forwarded to the proper committee of this bar association.
10. The Committee invites the co-operation of the Kansas State Bar Association so that the existence of this service may be properly publicized to the legal profession and to the public at large.

Respectfully submitted,

C. E. Joss, M.D., *Chairman*, Surgery  
 L. G. Allen, M.D., Radiology  
 C. R. Rombold, M.D., Orthopedics  
 J. W. Spearing, M.D., Industrial Medicine  
 E. M. Sutton, M.D., Internal Medicine.

#### HOSPITAL SURVEY

A. R. Hatcher, Chr., Wellington; Francis C. Basham, Eureka; F. C. Beelman, Topeka; C. E. Boudreau, El Dorado; I. R. Burkett, Ashland; Athol Cochran, Pratt; Thomas Dechairo, Westmoreland; G. R. Hastings, Garden City; O. W. Longwood, Stafford; Roy Moser, Holton; H. S. O'Donnell, Ellsworth; J. H. A. Peck, St. Francis; Lloyd W. Renolds, Hays; Marion F. Russell, Great Bend; J. B. Stoll, Clay Center.

#### To the House of Delegates:

Committee met in Topeka on September 14, 1945, in conjunction with meeting called by Dr. F. C. Beelman, secretary of State Board of Health. At this meeting many interested in Hospital Survey Program were represented as follows:

The Kansas Medical Society Hospital Survey Committee.  
 The Kansas Hospital Association Committee on Hospital Care.  
 Kansas Chapter American Institute of Architects.  
 Labor groups.  
 Farm groups.  
 The Kansas Chamber of Commerce.  
 The Kansas State Nurses' Association.  
 The Kansas Hospital Service Association, Incorporated.

The purpose of the first meeting was a conference of various committees that are definitely interested in the formation of a state wide Hospital Planning Commission.

As a result of this meeting a large Advisory Council representing those mentioned above was formed and an Advisory Commission has been elected to work in conjunction with the Advisory Council and the State Board of Health in the conducting of the State Hospital Survey.

The Advisory Commission of five members on Hospital Survey serves as the Advisory Council for Kansas Medical Society.

We feel that medical interests and hospital interests are well represented along with all other interested groups in this program.

The Advisory Commission of the Kansas Hospital Survey met in Topeka with full attendance on Saturday, January 26, 1946. We are pleased to report that the survey being conducted by the State Board of Health has completed or practically so, the survey of 42 counties and the work is being facilitated by additional personnel to hasten the completion of the survey.

Since the Committee has written all county medical societies asking their specific opinions regarding hospital needs, it will be greatly appreciated if the local county medical societies will co-operate in affording the information requested.

Respectfully submitted,  
 A. R. Hatcher, M.D., *Chairman*.

(Editor's Note: Since the report by the chairman of the Hospital Survey Committee was received, the Governor of Kansas has officially appointed the Advisory Commission and has named Dr. A. R. Hatcher chairman.)

#### INDUSTRIAL MEDICINE

C. R. Rombold, Chr., Wichita; J. L. Beaver, Wichita; C. H. Benage, Pittsburg; M. L. Bishoff, Topeka; C. E. Boudreau, El Dorado; Frank E. Coffey, Hays; C. W. Hall, Hutchinson; J. W. Spearing, Columbus; Director of Industrial Hygiene, State Board of Health, Topeka.

#### To the House of Delegates:

A meeting of the Industrial Medicine Committee was held in Wichita on November 18, 1945. A program detailing a comprehensive approach to the problem of industrial health in the state was drawn up. This program is to be discussed with representatives of Labor and with representatives of Industry in the near future. After these consultations it will be presented to the Council for adoption, alteration, or rejection. As soon as this program has been thoroughly outlined it will be implemented.

Respectfully submitted,  
 Charles Rombold, M.D., *Chairman*.

#### LOCATIONS

Robert G. Klein, Chr., Dodge City; I. R. Burkett, Ashland; B. A. Higgins, Sylvan Grove; C. O. Mays, Liberal; W. J. Pettyjohn, Kiowa; J. A. Poppen, Burr Oak; O. D. Sharpe, Neodesha; J. R. Shumway, Pleasanton; C. D. Updegraff, Greensburg.

#### To the House of Delegates:

Beginning in 1942, the Committee on Locations has faced an ever increasing problem concerning shortages of medical care. In addition to critical areas that resulted from physicians entering the armed forces, many others were occasioned or made acute because of deaths occurring among civilian doctors. Throughout the war years, the number of vacancies that were filled by incoming doctors was negligible.

Since the last annual meeting of the Society peace has been declared both in Europe and in Asia. Demobilization has returned many medical officers to civilian life, giving this committee the opportunity to relieve communities that have been without adequate medical care. Many requests have been received both from areas desiring doctors and from medical officers looking for locations in which to practice. These have been handled individually and will continue to occupy a large portion of the attention of this committee in the year to come.

It was early discovered that letters from lay persons or organizations within a community did not always represent the opinion of the profession. At times additional doctors were requested even though the need would be temporary since men in the service were planning to return. In an effort to obtain a true picture of the state and to be of greatest service to the profession, a questionnaire was mailed to the secretaries of all county societies. They were asked to survey the situation within their areas and to forward to this committee a report of all unusual situations, giving information regarding communities that needed additional medical care as well as those that were now taken care of. Very few replies have been received but those that were returned have been extremely helpful to the committee. We wish to state that in every instance where information was received from the medical society, the committee has given special effort to abide by the requests.

Almost daily medical officers inquire regarding locations in Kansas. The committee now has tabulated the names of many communities, grouped according to size and location. A separate list contains the locations where

specialized services are desired. Each request from an officer has been answered, and in many instances personal interviews have been conducted.

Several distinctive trends have been noted which probably will continue into the future. First is the fact that most returning medical officers prefer cities of 50,000 or more. Very few will consider an area that does not have a hospital, and almost none have been interested in the western section of the state. For the coming year these three situations will bring about the greatest problem.

This committee respectfully suggests that the House of Delegates give thought to those problems and if possible find some way in which solutions may be provided. We recommend that once again county societies be requested to submit information regarding locations so that complete information will be available over the entire state. We further recommend to the Hospital Survey Committee that communities now without hospitals in areas needing physicians be encouraged to build hospitals. We further recommend to the House of Delegates that some method be devised to present the attractiveness of western Kansas as a place to practice medicine and that returning officers be given this information. We further recommend that some means be found to notify the graduating class of Kansas University each year of desirable locations that are available in the state.

We wish to take this opportunity to express our gratitude for the continued and valuable assistance rendered this committee by Dr. F. L. Loveland and the Office of Procurement and Assignment and express our hope that in the future, as statistical information becomes more accurate, the work of this committee may be of considerably more value than it has been in the past.

Respectfully submitted,  
R. G. Klein, M.D., *Chairman.*

#### MATERNAL WELFARE

Robert E. Pfuetze, Chr., Topeka; Porter Brown, Salina; George E. Burkett, Kingman; L. A. Calkins, Kansas City; G. E. Cowles, Wichita; Paul R. Ensign, Topeka; Ben H. Mayer, Ellsworth; C. O. Merideth, Jr., Emporia; P. J. O'Connell, Kansas City; William L. Pratt, Leavenworth; M. J. Renner, Goodland; R. A. West, Wichita.

#### To the House of Delegates:

A meeting of your Maternal Welfare Committee was held October 7, 1945, and was well attended. At this meeting the activities of the State Board of Health in regard to maternal welfare were discussed at length. Their management of the E.M.I.C. program was commended, and it was the general opinion that this should be continued for a time with its present policies. In consideration of future programs of the State Board of Health it was felt that practical efforts to improve present standards of maternal and infant care should be extended. This is being accomplished by making instruction available to nurses and doctors and by providing equipment such as incubators where they will be of greatest service. Co-operation has continued through the year with the State Board of Health.

The need for short preceptorships to supplement present residencies in obstetrics for returning physicians was discussed and several are available on request.

Legislative and political measures affecting maternal welfare were outlined by Mr. Ebel. Opinion was unanimous that government interference in the form of the Pepper and similar bills should be condemned and support given to the prepayment plan of the Kansas Medical Society.

Respectfully submitted,  
Robert E. Pfuetze, M.D., *Chairman.*

#### MEDICAL ASSISTANTS

C. O. Merideth, Jr., Chr., Emporia; Cyril V. Black, Pratt; Harry J. Davis, Topeka; Arthur H. Dyck, McPherson; W. J. Feehan, Kansas City; C. L. VanPelt, Paola.

#### To the House of Delegates:

Members of this committee met with the Board of Directors of the Kansas Medical Assistants' Society in April, in September, and in December. This committee has attempted to help the medical assistants in their efforts to increase the value of the organization and its effectiveness to the medical profession.

In 1945 because of war-time bans on conventions the medical assistants held no meeting. Officers of the organization continued in their positions for a second year. The Kansas Medical Assistants' Society, however, has not been idle but has made several important innovations which we believe will be of interest to the medical profession.

A quarterly bulletin is prepared and distributed to all members. This bulletin contains announcements, suggestions for improving their service to the profession, and news of general interest.

During the past year the Constitution and By-laws of the Kansas Medical Assistants' Society have been completely revised and renovated. The new Constitution to be voted on at the annual meeting, just prior to the annual session of the Kansas Medical Society, has been published in the February issue of the Journal and may be considered part of this report.

The third departure from previous custom is the establishment of a two-day annual meeting to replace the former conference lasting only one day. A program of unusual interest has been prepared. Speakers will include Dr. Barrett A. Nelson of Manhattan, president of Kansas Physicians' Service, who will explain the medical society's pre-payment medical care plan; Dr. Robert H. Maxwell of Wichita, who will speak on "Management of the Female Patient"; and Mr. J. E. McCurdy of Topeka, general agent for the Medical Protective company, whose address will concern legal matters that affect the assistant in relation to the doctor's practice. Dr. W. M. Mills of Topeka, president-elect of the Kansas Medical Society, Dr. J. L. Kleinheksel of Wichita, president of the Sedgwick County Medical Society, and others will participate in this program. All members of the Kansas Medical Society are cordially invited and especially requested to attend, both because we believe the doctor will appreciate the high regard these girls hold for their position and because his presence will be encouraging to them.

During the past year active membership in this organization increased by 48, which again is an indication of continuing interest. Your committee cannot adequately express its appreciation for the services that have been rendered by the officers this year. This applies especially to Miss Zura Crockett, who has given a great deal of time and who, during the two years she has been president, has made many outstanding contributions to the medical profession. The organization will continue its efforts to increase membership until all persons employed in Kansas as assistants to physicians become active.

We heartily recommend this organization to the doctors of the Society and urge them to encourage their assistants to take an active part in its functions. Every activity is designed to raise the quality of service the medical assistant may offer to the doctor for whom she works. Therefore, this committee strongly believes that the Kansas Medical Assistants' Society deserves a far greater measure of support from the medical profession than it has received in the past.

Respectfully submitted,  
C. O. Merideth, Jr., M.D., *Chairman.*

### MEDICAL ECONOMICS

G. E. Kassebaum, Chr., El Dorado; H. E. Blasdell, Hutchinson; R. R. Cave, Manhattan; George E. Milbank, Wichita; O. W. Miner, Garden City; L. O. E. Peckenschneider, Halstead; J. W. Randell, Marysville; C. O. Shepard, Independence; Walter Stephenson, Norton.

#### To the House of Delegates:

Our committee on Medical Economics has not met this year. Undoubtedly there are things that might have been considered by the committee, but none that seemed urgent in view of the shortage of doctors and the time it would take from their work for a meeting. The veterans' set-up might have been our problem, but our president and the councilors handled it very efficiently without the committee. The Physicians' Service is handled by a special committee. The matter of the Kansas Athletic Accident benefit plan of the Kansas State High School Athletic Association is not satisfactory, but the cause of its troubles is apparent in its low premium and lack of actuarial experience.

To make this committee potent, it seems to me that all matters pertaining to socialized medicine, veterans' care, insurance plans, etc., should be cleared through this channel. Its members would then feel that it had matters of sufficient import to make the time spent in committee meetings worth while.

If there are any matters needing attention between now and the state meeting, we'll go into action.

Respectfully submitted,  
G. E. Kassebaum, M.D., *Chairman.*

### MEDICAL HISTORY

J. W. Randell, Chr., Marysville; C. D. Blake, Hays; W. F. Bernstorf, Winfield; J. F. Gsell, Wichita; George M. Gray, Kansas City; N. E. Melencamp, Dodge City.

#### To the House of Delegates:

The president, Dr. W. P. Callahan, in a letter appointing the chairman of this committee, stressed the necessity of getting out an accurate history of Kansas medicine with the suggestion that some of the older men of the Society be appointed on this committee. The committee pays its respects to a former committee under the chairmanship of Dr. Karl A. Menninger, who made a rather lengthy report which was published in the Journal of April, 1944. One interview was held with Prof. James C. Malin, Department of History, University of Kansas, Lawrence, Kansas, in which we were referred to "Local History—How to Gather It, Write It, and Publish It" by Donald Parker; and "An Introduction to Research in American History" by Hackett (MacMillan Company). Prof. Malin gave some helpful suggestions to the committee regarding subject matter and scope of the history. These suggestions will be available in the files of the committee.

The chairman spent several hours in the Chicago Public Library and found a limited amount of material in book form, most of which consisted of biographical sketches with photographs of medical men, the history of society organizations, and development of hospitals. However, it is the opinion of this committee that the history of Kansas medicine should not be produced on a biographical basis, but rather on an organizational basis.

It should be the duty of the future committee to decide exactly what materials should be included in the history and build up the machinery for the gathering of same. It is the opinion of this committee that the chairman of next year's committee be located in or near Topeka as it will be necessary for him to be near the Historical Society, the Editorial Board of the Journal, and the Cen-

tral Office. The Central Office should be the headquarters for the assembling and filing of materials.

The committee feels the desirability and necessity of the Society to allocate sufficient funds to carry on this work. We suggest that an amount of \$600 be allotted for this work annually for two or three years, or until such time as the history can be put into book form. We believe the work of this committee has progressed about as far as possible without allocation of funds. The committee further suggests that after this material has been collected that a recognized historian be employed to write same.

Respectfully submitted,  
J. W. Randell, M.D., *Chairman.*

### MEDICAL SCHOOLS

N. E. Melencamp, Chr., Dodge City; C. D. Blake, Hays; John J. Brownlee, Hutchinson; G. R. Hastings, Garden City; H. H. Jones, Winfield; F. L. Loveland, Topeka; Fred J. McEwen, Wichita; Alfred O'Donnell, Ellsworth; L. B. Spake, Kansas City; M. Trueheart, Sterling.

#### To the House of Delegates:

One meeting of this committee was held during the past year. It was at the medical school at Kansas City. The purpose of the meeting was to become acquainted with plans for the organization of a graduate school of medicine in connection with the University of Kansas. Besides members of the committee, various members of the faculty were present, and during the discussion agreement was reached on all points.

The graduate school, under the direction of E. H. Hashinger, M.D., will be flexible to serve the best interests of two groups. For the immediate future the primary concern will be to provide refresher courses for returning medical officers. Formal courses will be offered according to demands for this type of education. The length of these courses will be determined by the wishes of the men who apply for the work. For those who prefer refresher training in clinical experience, the members of the faculty invited returning medical officers to arrange to work with them. Details concerning these services vary with individuals and specialties involved, but in each case the faculty members expressed their desire to be of service. As a further project to aid the returning medical officer, approved residencies have been increased until now twice the pre-war number are available.

As the emergency passes the graduate school will be made entirely available to civilian doctors. Refresher courses will be given at any time sufficient interest is expressed to warrant the preparation of a course. The length of time will depend on the period for which this training is desired.

In general the faculty of the graduate school, Dean Wahl and Doctor Hashinger expressed the desire to make the graduate school of medicine at Kansas University of value to the physicians of Kansas and will welcome now or in the future any suggestions toward making this school more effective.

Respectfully submitted,  
N. E. Melencamp, M.D., *Chairman.*

### NECROLOGY

C. S. Huffman, Chr., Columbus; H. E. Blasdell, Hutchinson; J. G. Stewart, Topeka.

#### To the House of Delegates:

We, your committee, submit the following list of members of the Kansas Medical Society who have died during the past year:

Name	Age	Date	Place
Dr. Theodore Clark	1945	Feb. 12	Baldwin

## THE JOURNAL OF THE KANSAS MEDICAL SOCIETY

Dr. Albert A. Krugg	80	Feb. 17	Coffeyville
Dr. Samuel Murdock, Jr.	72	Feb. 26	Sabetha
Dr. Clarence S. Trimble	67	Mar. 16	Emporia
Dr. Ugo A. D. Collelmo	77	Mar. 25	Frontenac
Dr. James W. Sparks	67	April 9	Kansas City
Dr. Hugh L. Charles	54	April 13	Atchison
Dr. Joe Getty Reed, Jr.	31	April 18	Larned
Dr. M. A. Finley	76	April 26	Emporia
Dr. S. S. Glasscock	83	April 28	Goodland
Dr. J. B. Henry	67	May 8	Lawrence
Dr. E. B. Ebright	72	May 13	Wichita
Dr. Charles W. Cole	67	May 20	Norton
Dr. Mack L. Ross	66	May 21	Topeka
Dr. L. P. Ravenscroft	84	June 12	Winfield
Dr. Harry L. Aldrich	76	June 29	Caney
Dr. William E. Janes	58	July 5	Eureka
Dr. Walter J. Eilerts	64	July 9	Wichita
Dr. Forrest A. Kelley	67	July 14	Winfield
Dr. Joshua R. Bechtel	80	July 26	Lawrence
Dr. John W. Yankey	74	Aug. 6	Esbon
Dr. Otis B. Wyant	80	Aug. 11	Winfield
Capt. Lucien A. Watkins, M.C.	35	Aug. 20	Leavenworth
Dr. G. P. Marner	89	Sept. 7	Marion
Dr. Bertram Johnson	68	Sept. 12	Eureka
Dr. Enos R. Cheney	74	Oct. 9	Gypsum
Dr. Howard L. Clarke	77	Oct. 19	LaCygne
Dr. Fred E. Angle	45	Oct. 30	Kansas City
Dr. Andrew Jackson Smith	82	Oct. 31	Leavenworth
Dr. Thomas Richmond	73	Nov. 4	Kansas City
Capt Paul B. Young, M.C.	35	Nov. 10	Wichita
Dr. Patrick S. Brady	56	Nov. 12	Hays
Dr. Frederick C. Tyree	62	Nov. 24	Agenda
Dr. F. E. Dargatz	59	Nov. 30	Kinsley
Dr. Oscar N. Clark	59	Dec. 7	Greeley
Dr. Guy S. Graham	73	Dec. 10	Wetmore
Dr. Opie W. Swope	64	Dec. 12	Wichita
Dr. Roscoe C. Leinbach	61	Dec. 14	Onaga
Dr. Charles W. Robinson	55	Dec. 20	Atchison
Dr. Charles F. Attwood	63	Dec. 25	Topeka
		1946	
Dr. John W. West	73	Jan. 2	Narka
Dr. Leslie C. Bishop	63	Jan. 6	Wichita
Dr. D. W. Relihan	91	Jan. 6	Smith Center
Dr. Charles H. Fortner	72	Jan. 11	Coffeyville
Dr. Eugene E. Wallace	66	Jan. 11	Norwich
Dr. Tracy R. Conklin	78	Jan. 19	Abilene
Dr. Thomas S. Finney	52	Jan. 29	Wichita
Dr. Joseph J. Michalak	50	Feb 3	Humboldt
Dr. Hiram T. Jones	72	Feb 6	Lawrence

**PHARMACY**

R. T. Nichols, Chr., Hiawatha; W. L. Anderson, Atchison; Guy E. Finkle, McPherson; John L. Grove, Newton; L. E. Ketner, Fort Scott; G. E. Martin, Concordia; E. M. Sutton, Salina.

## To the House of Delegates:

A number of problems came to the attention of the Committee on Pharmacy during the past year, the most important of which was the matter of relations between physicians and pharmacists. At the invitation of the board of directors of the Kansas Pharmaceutical association, members of the committee met with them on November 25, 1945, in an effort to obtain better understanding between the groups. A resume of the minutes of that meeting will comprise the report of the committee.

The first discussion dealt with the problem of narcotics, and as a result of a recommendation made at that time the executive secretary of the Kansas Medical Society secured complete information on narcotic regulations from

the district supervisor of narcotic control for this area. By order of the council a summary of this information was compiled and mailed to every member of the Society and to the secretary of the Kansas Pharmaceutical association and was printed in the Journal of the Kansas Medical Society (January 1946).

It was also recommended that a member of the Federal Bureau of Narcotics be invited to speak to the graduates of the medical school each year and explain legal distribution of narcotics and pertinent regulations.

Pharmacists are of the opinion that barbiturates present a greater problem than do narcotics, and they recommend that the state regulate the use of these drugs. It was suggested that the Board of Health be asked to foster legislation to place barbiturates under state control.

The matter of indigent medical care and druggists' participation in this program was next discussed, and it was recommended that the pharmaceutical association study this problem to see if it is possible for druggists to co-operate.

A number of other matters, having to do with relations between individual doctors and pharmacists, were discussed and, although relations have been good in the past, it was decided that members of the two professions in the various counties should meet together to formulate plans for mutual benefit.

The Committee on Pharmacy believes that this meeting was productive of better understanding between the groups and recommends that similar meetings be held in the future.

Respectfully submitted,

R. T. Nichols, M.D., *Chairman.*

**PLASMA**

W. F. Bernstorf, Chr., Winfield; R. W. Emerson, Topeka; William Holwerda, Lindsborg; G. E. Kassebaum, El Dorado; H. O. Loyd, Arkansas City.

## To the House of Delegates:

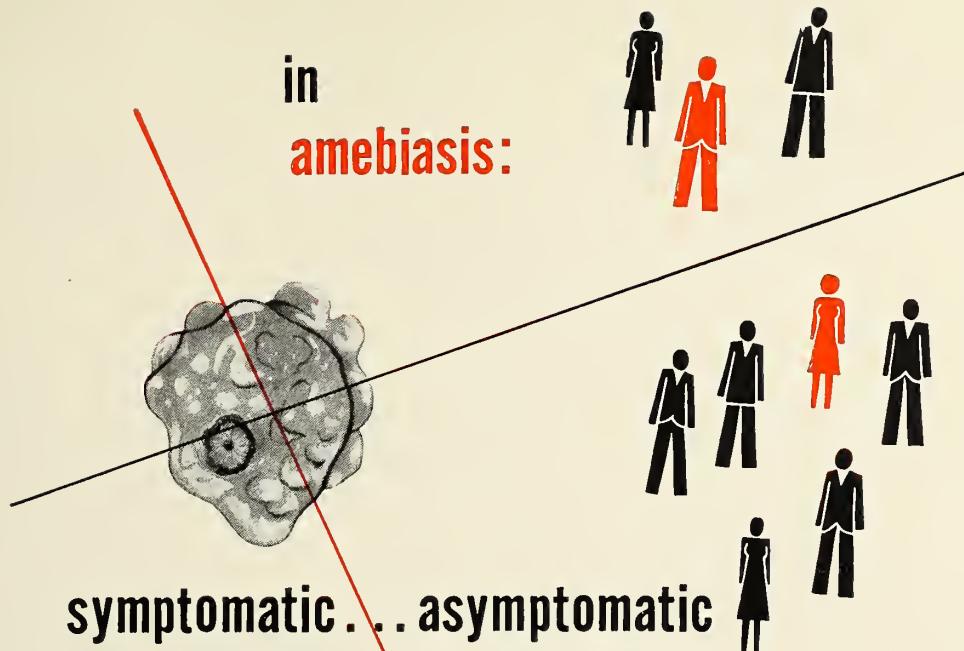
We are pleased to report the progress of the Plasma Committee during the past year with two very definite accomplishments:

First, the Plasma Committee, in co-operation with the Kansas State Board of Health, has set up the machinery for the distribution of the surplus plasma of the armed forces through the auspices of the American Red Cross. Under this plan we expect to be able to supply every hospital in the state and every licensed and practising physician and surgeon with at least one or possibly more units. In addition the State Highway Department may also be supplied as well as other possible strategic locations. This plasma is being furnished free of charge and the only requirement is that the container be returned to the State Board of Health when empty. It is the aim of the Red Cross to supply sufficient plasma for every need and the physicians of the state are being urged to use it freely.

The second feature of importance is as follows: During the past year the Plasma Committee has secured the recommendation of the Council of the Kansas Medical Society and also the approval of the Kansas State Board of Health to the end that Kansas is joining a select group of states for the producing and processing of free plasma and blood derivatives for the people of Kansas. We estimate that the surplus plasma will probably be largely used by the end of two years at which time we hope to have the necessary equipment and facilities in operation to continue the supply of plasma on a free basis for the people of Kansas.

Respectfully submitted,

Warren F. Bernstorf, M.D., *Chairman.*



Barr<sup>1</sup> states: "... it is just as important to treat properly the symptomless 'carrier' of this parasite as to treat the patient suffering from amebic dysentery."

Stitt, Clough and Clough<sup>2</sup> report, "The disease may be symptomless . . . These mild or symptomless cases have been shown to outnumber greatly the cases with clinical dysentery. They constitute the carriers or 'cyst-passers'."

DIODOQUIN (5, 7-diiodo-8-hydroxyquinoline) is safe to use even in suspected cases of amebiasis. Nonirritating, nontoxic—Diodoquin has been found promptly destructive to protozoa in amebiasis and *Trichomonas hominis* (*intestinalis*).

## **DIODOQUIN**

1. Barr, D. P.: *Modern Medical Therapy in General Practice*, 2:1830, Baltimore, Williams & Wilkins Company, 1940.

2. Stitt, E. R.; Clough, P. W., and Clough, M. C.: *Practical Bacteriology, Haematology and Animal Parasitology*, ed. 9, Philadelphia, P. Blakiston's Son & Co., 1938, pp. 410-412.



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### POSTGRADUATE STUDY

H. H. Jones, Chr., Winfield; F. C. Beelman, Topeka; C. H. Benage, Pittsburg; L. B. Gloyne, Kansas City; J. A. Howell, Wellington; J. L. Lattimore, Topeka; Ben H. Mayer, Ellsworth; J. H. A. Peck, St. Francis.

To the House of Delegates:

One meeting of the entire committee was held, in conjunction with a meeting of the councilors to determine a policy for the coming year. A sub-committee was appointed by Dr. Callahan to expedite the policy of the general committee.

To date, 27 applications have been received and acted upon. Seventeen cases have been completed, and checks forwarded. A total of \$3,400 has been disbursed. It is anticipated that greater calls will be made in the spring of 1946 and the cases can be cleared more rapidly. The total sum contributed as of February 1, 1946, is \$42,642.25. This includes interest on bonds.

The recipients of these funds express gratitude to the members for this gesture of friendship and wish to thank the entire Society.

Respectfully submitted,  
Harold H. Jones, M.D., *Chairman.*

### PUBLIC HEALTH AND EDUCATION

R. R. Cave, Chr., Manhattan; O. W. Davidson, Kansas City; O. H. McCandless, Marion; Walter N. Mundell, Hutchinson; C. Herbert Munger, Emporia; L. S. Nelson, Salina; George I. Thacher, Waterville; J. E. Wolfe, Wichita.

To the House of Delegates:

Although this committee has not held a formal meeting, recommended principles have been suggested through correspondence among committee members and in conversation. Many of these principles have been brought to the attention of the Council and are in action at this time or are being prepared for action. Interest has largely been confined to education rather than public health and it is to that field, sometimes called public relations, that most of the following applies.

The philosophy governing the activities of various medical societies is largely changing from an isolationist attitude to one of explaining to the public the services that organized medicine has to offer. This change may be noted in the American Medical Association. The recently organized Council on Public Relations has gained momentum and is at last being given a sizable budget with which to operate. Numerous state societies are adding assessments to their dues to cover activities in the field of public relations. The Kansas Medical Society, through its Council, has expressed an interest in expanding its public relations program and will shortly intensify its activities in that direction. These plans have all originated with this committee or have been approved by its members.

It is recommended that each component society shall organize a committee that will co-operate with the committee of the state society. The primary function of county committees at present shall be to organize an effective speakers' bureau. The speakers' bureau shall have available physicians who will speak to lay audiences on medical subjects. They could be drawn from by local requests or during special occasions, such as cancer control month, might be utilized by the state society. This speakers' bureau should also be responsible for public relations activities within the county. It is strongly urged that a committee rather than an individual be given this responsibility.

The Kansas Medical Society will attempt to prepare more information for the press. At first this will consist of news items concerning services of the society but will

later include announcements regarding scientific advancements and general instructions toward preservation of better health. That the Kansas press welcomes material of this kind is evidenced by the frequency with which these items appear. Upon the suggestion of this committee, the Journal of the Kansas Medical Society has been publishing each month a section entitled The Kansas Press Looks at Medicine, where examples of press releases of general interest are reprinted.

The Council has voted unanimously to establish a radio program to appear weekly if possible and to accomplish this at the earliest possible time. This is receiving attention at present.

This committee has brought to the attention of all committee chairmen that the over-all program of education should include as wide a range of subjects as possible. Each committee has been invited to co-operate in this program by submitting material that might be used either through press or radio. Many committees have expressed their interest in this program and one in particular has made a beginning in that direction. The Kansas Obstetrics and Gynecological Society, through the Committee on Maternal Welfare, prior to Mother's Day last year sent a letter on maternal health to ministers, newspaper editors and other influential persons. The committee will welcome the receipt of regular material from all committees. Arrangements for dissemination of information are completed. It now rests with the society as a whole and its various committees to carry this project forward.

Respectfully submitted,  
R. R. Cave, M.D., *Chairman.*

### PUBLIC POLICY

To the House of Delegates:

The Public Policy Committee has been expanded to include membership in nearly every county of the state.

The chief efforts of the Public Policy Committee at the present time are directed to the efforts of maintaining high medical standards for the state of Kansas. The co-operation of the entire membership of our Society is necessary in this effort and active work must be carried out continuously.

Further reports will be made at appropriate times.

Respectfully submitted,  
Henry N. Tihen, M.D., *Chairman.*

### SCIENTIFIC WORK

Irene Koeneke, Chr., Halstead; G. F. Corrigan, Wichita; C. A. Hellwig, Wichita; R. Y. Jones, Hutchinson; Dwight S. Lawson, Topeka; L. C. Murphy, Wichita; Frances Schiltz, Wichita; H. R. Wahl, Kansas City.

To the House of Delegates:

The exigencies of medical practice during our fourth war year could have been a ready and justifiable excuse for omission or delay in activities of a scientific nature among the members of the Kansas Medical Society.

The scientific programs of county medical societies have been carried on by members who have been on call more continuously than ever before in the history of medical practice except in times of epidemics. In addition these men have prepared papers for hospital groups and units of the armed forces which were located in their midst, in order to keep the physicians in these camps abreast of the problems of civilian practice.

A cursory examination of medical literature from May 1945 to February 1946 has revealed that 45 scientific articles have been published by 37 Kansas physicians in 16 state and national medical journals. Eighteen of these physicians had articles published in our own state

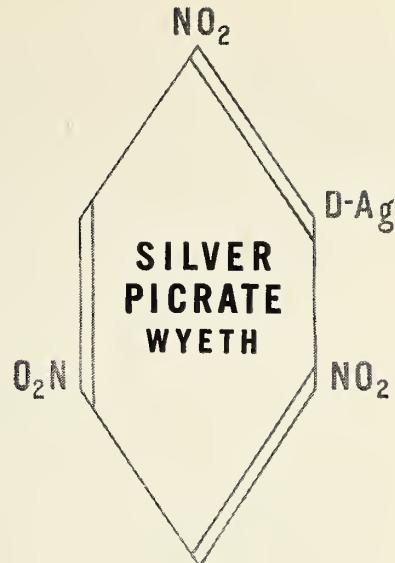
# PICRAGOL

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**PICRAGOL** is an effective agent in the treatment of urethritis and vaginitis. Its specific action is especially valuable for the control of trichomoniasis or moniliasis of the vagina and for trichomonas infections of Bartholin's or Skene's glands.

**PICRAGOL CRYSTALS**, Bottles of 2 grams. • **COMPOUND PICRAGOL POWDER**, Silver Picrate Wyeth, 1 per cent, in a kaolin base. Packages of six 5 gram vials. • **VAGINAL SUPPOSITORIES PICRAGOL**, Silver Picrate Wyeth, 0.13 grams, in a horoglyceride-gelatin base. Packages of 12. • **VAGINAL SUPPOSITORIES PICRAGOL, for infants**, Silver Picrate Wyeth, 65 mg., in a boroglyceride-gelatin base. Packages of 12.



*Wyeth*

journal. Other journals are as widespread as New England, Florida and California.

We offer our congratulations and appreciation to these men who have given of their time and ability above and beyond the call of duty, to further the scientific standards of our profession.

Respectfully submitted,  
Irene A. Koeneke, M.D., *Chairman.*

#### STORMONT MEDICAL LIBRARY

Don C. Wakeman, Chr., Topeka; W. M. Mills, Topeka; R. I. Canuteson, Lawrence; R. B. Knight, Topeka.

To the House of Delegates:

This committee has functioned without a called meeting during the past year but has done considerable work individually, especially during the time of the last legislative session. It was discovered that the legal profession in Kansas was interested in organizing a medical library comparable to the law library that is now supported and operated by the state. Assistance from the legal profession made it possible to obtain an appropriation from the legislature sufficient to buy shelving and to employ a full time medical librarian. As soon as materials can be obtained, medical books and periodicals will be catalogued and placed in a room apart from the law library. These will then be available to the medical profession in Kansas as well as to the lawyers.

Returns from the Stormont Medical Library fund have been small during the past few years, barely large enough to cover the subscription cost of the few magazines that are purchased. It is believed that in the future this fund can be augmented through legislative appropriations, and when that is done it is recommended that this committee take an active part in the selection of books. A further recommendation for future activities of this committee would include publicity to the profession on the fact that the library is available for their use. If interest could be created among the doctors of Kansas in the establishment of a state library, it is possible that additional books and periodicals could be obtained through donations from the doctors of this state.

Respectfully submitted,  
Don C. Wakeman, M.D., *Chairman.*

#### STUDY OF HEART DISEASE

Fred J. McEwen, Chr., Wichita; C. M. Alderson, Dodge City; James A. Butin, Chanute; George A. Chickering, Hutchinson; George F. Corrigan, Wichita; T. T. Holt, Wichita; H. H. Jones, Winfield; E. D. Liddy, Jr., Lawrence; Herlan O. Loyd, Arkansas City; Harold T. Morris, Topeka; George E. Paine, Hutchinson; L. O. E. Peckenscheider, Halstead; J. G. Stewart, Topeka; George A. Walker, Kansas City.

To the House of Delegates:

For numerous reasons the Committee on the Study of Heart Disease did not meet this year. Pressure of work and travel difficulties have been experienced equally by all committees, but our problem had an additional complicating factor that ruled against an attempt to have a meeting.

The Committee on the Study of Heart Disease is interested in two main objectives. The first of these is to provide for the profession a more adequate knowledge of this subject. It is easily understandable that graduate clinics in heart disease would have been impractical during the war, both because of physicians' inability to attend and because of difficulty in providing speakers.

The second major project of concern to this committee is public education. This program is being contemplated but should not be introduced until the profession has

been prepared to care for the additional patients that might apply for assistance as a result of publicity.

It is recommended that upon the return of medical officers now in service, thereby providing more adequate distribution of medical care throughout the state, the committee become active and prepare for a series of clinics on the study of heart disease; that these clinics be conducted in several places over the state, and that shortly thereafter a lay educational campaign be prepared and sponsored by this committee. Initial plans will be made for such a program at a meeting to be called during the time of the annual session of the Kansas Medical Society at Wichita.

Respectfully submitted,  
Fred J. McEwen, M.D., *Chairman.*

#### VENEREAL DISEASE

J. E. Wolfe, Chr., Wichita; O. W. Davidson, Kansas City; B. M. Marshall, Topeka; George B. Morrison, Wichita; Harold Neptune, Salina; M. J. Renner, Goodland; J. V. VanCleve, Wichita; Director of VD Control, Board of Health, Topeka.

To the House of Delegates:

A meeting of the Committee on Venereal Disease was held at the city hall in Wichita on Sunday, October 28, at 10:00 a.m. Present were: Dr. J. E. Wolfe, Wichita, chairman, Dr. H. S. Neptune, Salina, Dr. J. V. VanCleve, Wichita, Major R. M. Sorenson, State Board of Health, Topeka, and Mr. Oliver E. Ebel.

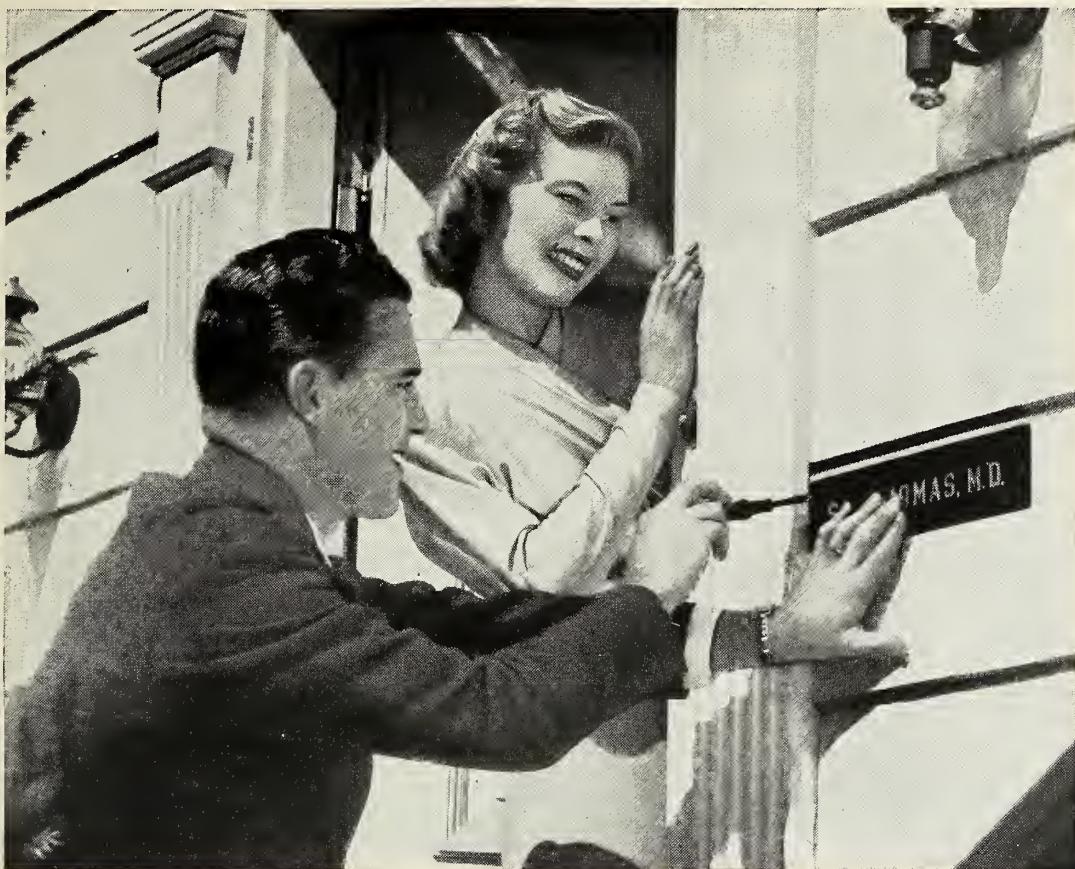
The problems considered were: Reporting, Education, Diagnosis and Treatment.

It was agreed that the reporting of syphilis each year was considerably better than that of gonorrhea, but that if adequate control measures are to be maintained, the physicians of Kansas should be asked to give the matter of reporting a little more serious attention.

A review of the educational programs in Kansas was made but it was felt that they do not reach all the doctors in the state at this time. Considerable literature is available and not infrequent refresher courses have been offered. It is thought that with the newer ideas of diagnosis and treatment that physicians in general should be encouraged to attend such refresher courses as are made available.

It was the consensus of opinion that at the present time the matter of diagnosis of both syphilis and gonorrhea is possibly a major problem. Due to the fact that a high per cent of false positive reactions have been discovered in men passing through separation centers, the Army has attempted to get men to stop at diagnostic centers following separation from the armed forces. At present there are no diagnostic and treatment centers in the state of Kansas. After studying the types of treatment available in other parts of the United States it was quickly decided that quick treatment is difficult and requires well trained personnel and definitely requires hospitalization. For these reasons a motion was made and passed that diagnostic and treatment clinic service be started in Kansas as soon as possible, but that for the time being it be encouraged only in the city of Wichita and the University of Kansas hospitals, and that any attempt at the establishment of any other centers be withheld until the procedures become more standardized or more simplified. The action taken here was in no way intended to direct or interfere with private practice and applied only to such clinics as might receive financial assistance from the State Board of Health.

Respectfully submitted,  
J. E. Wolfe, M.D., *Chairman.*



## There is a Doctor in the House

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of \$15,000 and 7 years'  
hard work and study  
to get him there!*

● Proudly he "hangs out his shingle," symbol of his right to engage in the practice of medicine and surgery. But to a doctor it is more than a right: it is a privilege—the privilege of serving mankind, of helping his fellow man to a longer, healthier, and happier life.



According to a recent  
nationwide survey:  
**More Doctors  
Smoke Camels  
than any other cigarette**

## KANSAS PHYSICIANS' SERVICE

Kansas Physicians' Service has passed the initial stage where planning and theory occupy major consideration. Today prepaid medical care is available to the people in Kansas if purchased in groups. The one exception to this regulation applies to returning service men. A service man may join Kansas Physicians' Service on an individual basis at any time within 60 days following his discharge.

This prepayment plan sponsored by the Kansas Medical Society is being favorably received. After only two complete months of operation, there are now enrolled 85 groups, covering more than 4,000 individuals. The first few months in any new venture are largely devoted to explaining and planning. Enrollment results therefore are highly encouraging and should rapidly increase within a few months. Already five claims have been presented to Kansas Physicians' Service and have been authorized for payment. These include two surgical procedures, one non-surgical illness and two accidents.

Within a few days an important letter concerning Kansas Physicians' Service will be mailed to each member of the Society. Complete explanatory information will be contained. The official fee schedule will be included and should be retained for permanent reference. Copies of the physician's report will be sent so that claims may be made on the approved standard form. A participating physician's agreement card will be sent to each doctor in the Society who has not yet signed to co-operate with Kansas Physicians' Service.

There is a new development of national scope regarding medical care programs. Until now the 30-odd medical care plans in the United States have struggled for some semblance of unity and have exerted whatever pressure could be brought to bear on the American Medical Association for something stronger than tolerance. Upon their own initiative the various states having medical care plans attempted to organize a council. Considerable enthusiasm has also been noticed recently in the effort to create a national insurance plan whereby organizations engaged in inter-state commerce could enroll without the inconvenience of doing business with each state separately.

For some time the House of Delegates of the American Medical Association has voiced its approval of medical care plans. The Board of Trustees created a Council on Medical Service, but the need for leadership through the A.M.A. remained unanswered as far as practical assistance was concerned.

In February 1946 all of this changed. The Board of Trustees took a forward step that will be of far-reaching benefit not only in assisting state-wide medical care programs but in the over-all struggle to combat undesirable Federal legislation. Perhaps no single decision of the A.M.A. in recent years has been as indicative that there is within that organization a new concept of its responsibility and its strength.

The Council on Medical Service and Public Relations has employed Mr. Jay Ketchum, formerly of Michigan Medical Service, as director of a new bureau, as yet unnamed, to be located in the A.M.A. building. Under his direction will be all activities for unifying and assisting prepayment medical care plans. There will be

set up a speakers' bureau. Employed will be a public relations expert, an actuarian, etc. Already appropriated by the Board of Trustees to cover operating expenses for the remainder of this year is \$50,000.

The American Medical Association has also moved to set up a corporation to be known as the Associated Medical Care Plans, Inc. A commission of five doctors, five laymen and three doctors from the Council on Medical Service and Public Relations will direct the corporation. The president is Dr. Frank Feierabend of Kansas City, Missouri, the secretary and director is Jay Ketchum, and the vice-president is Mr. William Bowman of California Physicians' Service. This commission will invite all state medical care plans to participate. Dues will be in accordance with the amount of business being written by each medical care plan on the basis of one and one-fourth mills per contract per month. The minimum will be \$25 a year and the maximum \$250.

The Associated Medical Care Plans, Inc., will create and approve a national emblem and will arrange to solve the problem of a national insurance company. Through the Council on Medical Service and Public Relations, standards will be set up and an official seal may be used by all plans meeting the qualifications.

Co-operation in this program by Kansas Physicians' Service is expected. The plan was approved and the A.M.A. was complimented for this forward step by the Executive Committee. Official decision of Kansas Physicians' Service will be reached at the annual meeting to be held in Wichita on Monday, April 22, 1946.

### Foundation to Combat Arthritis

With President Truman as its honorary chairman, a new national foundation to combat arthritis was announced last month by Mr. Louis Kranitz, chairman of the national campaign committee. A goal of two and one-half million dollars is being sought for the establishment of the National Arthritis Research Foundation, with headquarters to be located in Hot Springs National Park, Arkansas.

### County Societies

The following officers were elected at a recent meeting of the Rice County Medical Society: president, Dr. E. R. Hill, Lyons; vice president, Dr. H. L. Patterson, Bushton; secretary-treasurer, Dr. George Gill, Sterling.

\* \* \*

The regular monthly meeting of the Saline County Medical Society was held February 14 at the Cafe Casa Bonita, Salina. Dr. Charles Rombold, Wichita, spoke on differences of diagnosis of orthopedic causes of backache, and Dr. J. P. Berger, Wichita, discussed dermatologic problems of general interest.

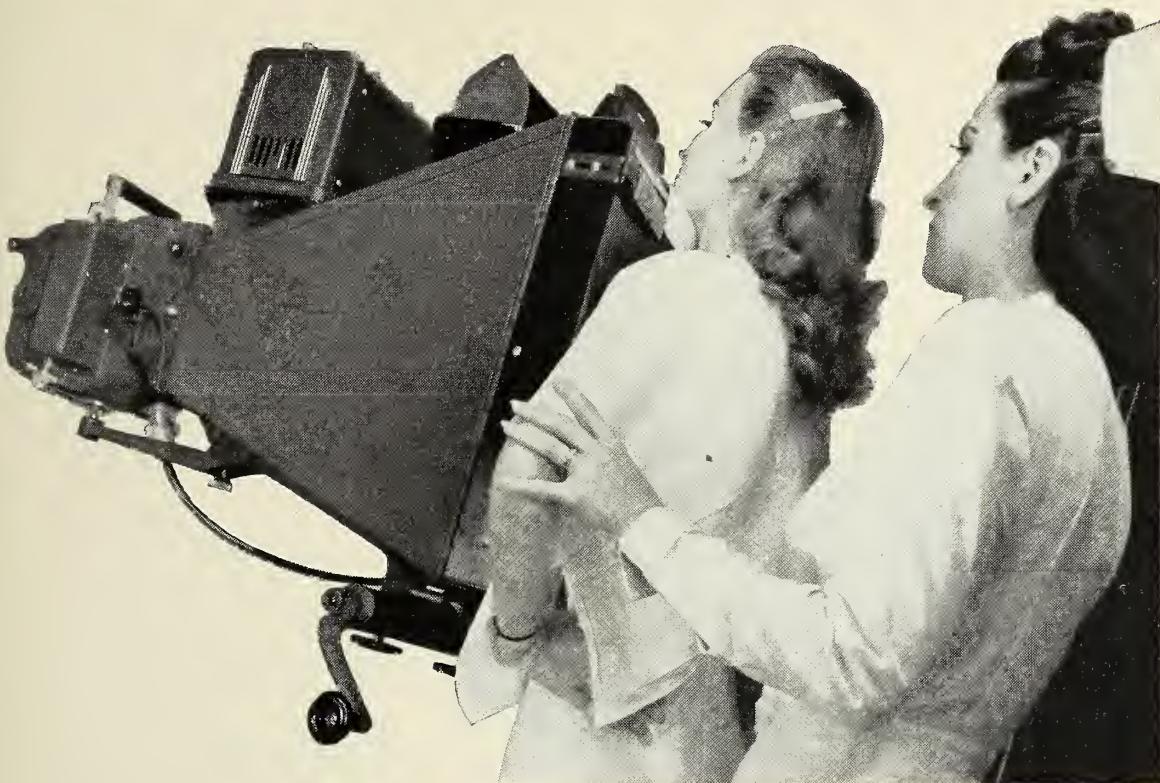
\* \* \*

Members of the Cherokee County Medical Society met at the county health department offices in Columbus February 19. Guests of the group were Dr. Leon Bauman and Dr. Albert Bair of Parsons, Dr. C. E. Benage and Dr. Allen Parish of Pittsburg, and Mr. Evan Wright, director of the Food and Drug Division of the State Board of Health.

Dr. Benage, councilor of the third district of the Kansas Medical Society, explained the Kansas plan for care of veterans and presented a discussion on cancer of the colon with numerous x-ray films as illustrations.

During the business session Dr. J. W. Spearing, Columbus, was named delegate to the state meeting and Dr. H. L. Bogan, Baxter Springs, was elected alternate.

# Is Your Community Awaiting an X-Ray Chest Survey?



Through well-directed educational campaigns sponsored by tuberculosis organizations throughout the nation, men, women, and children have been learning about technological developments which today make it economically feasible to conduct x-ray chest examinations of large groups of people for the purpose of detecting unsuspected tubercular infections in apparently healthy individuals.

Public interest having been so thoroughly aroused, many communities have adopted individually planned x-ray chest survey programs as a most effective measure for tuberculosis control—for screening out and isolating individuals who, "ignorant of the fact that they have the disease, unknowingly jeopardize their own lives and the lives of those with whom they come in contact."

Come the time when such a survey is suggested for your community, and your professional advice probably sought by the local tuberculosis society, we shall be glad to help

you prepare a summary which would evaluate the various methods and facilities used for different types of chest surveys. These evaluations, may we assure you, will be unprejudiced, as G-E photo-roentgen apparatus is not limited to but one model, nor restricted to the use of one size of film. Address General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Illinois.



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## AUXILIARY

### Annual Meeting April 22-25

Plans are now being completed for the first post-war meeting of the Woman's Auxiliary to the Kansas Medical Society, and your officers are preparing to make this session one that will be long remembered by every member who attends. Since last year's meeting was confined to business activities, this year's program will be doubly interesting.

Some details of the program are yet to be worked out, but a number of speakers have accepted invitations to address our group. Mrs. David W. Thomas of Lock Haven, Pennsylvania, president of the Woman's Auxiliary to the American Medical Association, plans to be present, and Mrs. Jesse D. Hamer of Phoenix, Arizona, president-elect of the national organization, hopes to attend. One of our most prominent speakers is Mrs. Luther H. Kice of Long Island, New York, chairman of our national committee on legislation.

Monday, April 22, will be play day for the Auxiliary. There will be golf and bridge during the afternoon, with possibly a tour to some point of particular interest in Wichita and a tea. The day's program will be ended with a dinner.

Auxiliary registration will begin at eight o'clock in the morning, Tuesday, April 23, and will continue until six in the evening. The Board of Directors will meet that morning at ten o'clock at the Allis hotel. At one o'clock there will be a luncheon honoring members at large, and at two o'clock a tea will be given. Mrs. Kice will be guest speaker at the tea. A dinner honoring county presidents will be served in the evening.

Registration will be continued through Wednesday, April 24, beginning at eight o'clock. The day's program includes a general session at the Allis hotel at 9:45, a luncheon honoring state officers, a post-board meeting in the afternoon, and a banquet in the evening in conjunction with the medical society.

The program for Thursday, April 25, has not been decided upon and it has been suggested that the day be left free. Definite announcement will be made at a later date.

### President's Message

As another year of Auxiliary work draws to a close, we wish that there were more time to complete some of our undertakings. The organization of several new units is a possibility, and many new members can be enrolled as medical officers and their wives return to Kansas communities. We are optimistic about future expansion and know it will be accomplished under the fine leadership of your incoming president, Mrs. H. L. Regier.

Saturday afternoon as we listened to the A.M.A. radio program we wished that every member was also listening. The action depicted the success of a doctor's wife in correcting bad health conditions in the community. It impressed us with a realization that public health is often endangered because we are prone to feel that action in such matters is the responsibility of someone else.

It was a shock to learn that the A.M.A. has been informed that the Y.W.C.A. is to approve the Wagner-Murray-Dingell bill at its national convention this month. We feel sure that it must be due to a misunderstanding of its intent. We have also been told that the P.T.A. is approving the measure. Realizing the disastrous effect of the

sponsorship of these organizations, we know that we too must act. Explain to your friends just what this bill provides, doctors serving on a salary, regardless of the number of patients treated, patients being served by doctors whose panels happen not to be filled, no assurance that the same doctor will be available for continued treatment. Explain that it is likely to induce mechanical rather than personal attention, that the private practice of medicine will be destroyed. Then present the plan offered under Kansas Physicians' Service.

When a woman asks, "What good can the Auxiliary accomplish?" tell her the answers and be sure that you know whereof you speak.

Sincerely yours,

Mrs. Hugh A. Hope.

### President's Visits

Your president appreciates the courtesies shown her by the various units over the state. On February 4 it was our privilege to be a guest of the Shawnee county group at a public relations tea. We enjoyed their hospitality and that of Mrs. Homer Hiebert, county president, and Mrs. Floyd Beelman, state vice president, who were hostesses at a dinner for state officers.

We were a guest of the Saline county group on February 14 at a delightful dinner given by Mrs. Earl Vermillion. The members showed keen interest in the program of the Auxiliary. On February 27 we were in Parsons to meet with the Labette county unit, another active and progressive group.

Mrs. Hugh A. Hope.

### The Meaning of Membership

Today men and women in the armed forces, and the civilians at home, are fighting and working to defend and preserve "our way of life."

Our doctors of medicine have been fighting for "our way of life" since 1540 A.D., at which date in history the early schools of medicine arose.

Our way of life: preventive medicine, sanitation, good housing, pre-natal care, nutrition, and we could go on and on.

All energy today is directed toward victory over our foes in war. As members of an Auxiliary to the profession of Doctor of Medicine, we may think of victory in connection with that profession. Our doctors of medicine have been victors in their war on disease that threatens mankind, and many have given their lives in attending their professional duties, as for instance in contagious diseases. Victory is theirs in insulin, in the treatment of diabetes, in the use of sulpha drugs, and in the thousand and one modalities of 20th century medicine, of the prevention, control and treatment of human disability.

May I urge you to exercise the privilege of membership in an Auxiliary to this noble profession.—*Mrs. Ralph Eudsen in Bulletin of Woman's Auxiliary to the A.M.A., March, 1943.*

### Auxiliary Meeting

The February meeting of the Sedgwick County Medical Auxiliary was held at Droll's English Grill with Mrs. H. N. Tihen as chairman. Also on the committee were Mesdames R. C. Howard, G. B. Morrison, H. W. Palmer, G. W. Kirby, G. A. Spray, J. L. Kleinheksel and J. L. Evans. Decorations were in the Valentine theme.

Mrs. J. W. Shaw, program chairman, introduced Mrs. H. W. Ralstin who gave a talk on February.

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## KANSAS MEDICAL ASSISTANTS' SOCIETY

### State Meeting April 21 and 22

Members of the Kansas Medical Assistants' Society are reminded again that a special program is being planned for their enjoyment at the time of the state meeting at the Allis hotel at Wichita, Sunday and Monday, April 21 and 22, 1946, immediately preceding the days set aside for the annual meeting of the Kansas Medical Society.

Because of ODT regulations the assistants held no meeting last year, which doubles interest in this year's session. Members of the Sedgwick County Medical Assistants' Society, the hostesses, are sparing no effort in arranging a program of educational value and genuine interest to personnel in doctors' offices. Miss Zura Crockett of Wichita, state president, assures all members that the time spent in attendance will be most profitable.

Registration fee for the meeting is three dollars. The registration desk will be open from nine o'clock Sunday morning until early afternoon, and for the benefit of those who attend on the second day only, will be open again Monday morning from nine o'clock to 9:30.

Dr. John Kleinheksel, president of the Sedgwick County Medical Society, will give the address of welcome at the first session, starting at two o'clock Sunday afternoon. The response will be given by Dr. W. M. Mills, Topeka, president-elect of the Kansas Medical Society. All members of the Kansas Medical Society are invited to attend this session, and it is hoped that a number of doctors will take advantage of this opportunity to become familiar with the objects of the assistants' organization.

Mr. J. E. McCurdy, Topeka, general agent for the Medical Protective company, will address the group on "Safeguarding Your Doctor's Interest," after which Dr. Barrett A. Nelson, Manhattan, will explain the operation of Kansas Physicians' Service. These two addresses will be of practical benefit to all medical assistants. The session will be closed with music by the Wesley nurses' chorus under the direction of Margaret Motter and remarks from the medical advisors to the assistants' society.

Members of the Sedgwick county group will be hostesses at an "open house" Sunday evening from five to seven o'clock. This informal gathering will be an opportunity for all members, old and new, to become better acquainted and to discuss problems of mutual interest.

The meeting on Monday morning will be called to order at 9:30. The day's program has not yet been completed, but it is known that Dr. Robert H. Maxwell, Wichita, will give an address on "Management of the Female Patient," and a round table discussion will be held. A luncheon will follow the program.

Many important matters of business will be presented at the afternoon session on Monday, including a vote on the proposed amendments to the constitution and by-laws. These proposed amendments were printed on page 74 of the February issue of the Journal of the Kansas Medical Society, and it is urged that all members study these proposals before the time of the meeting. The session will be closed with installation of new officers.

Although the Kansas Medical Assistants' Society is a comparatively new organization, it has grown steadily since the first meeting was held in Wichita in May 1940. It was decided at that time that an annual session should be held, and the group met again in Topeka in May 1941 and continued its program of annual meetings until the war

interfered. It was unfortunate that no meeting could be held in 1945, but the officers graciously consented to continue their work for another year to keep the organization active. They have worked hard to maintain interest in the face of such difficulties, and are deserving of the appreciation of every member throughout the state.

The Society has been helpful to all its members, and it is hoped that a record attendance at this year's meeting will give impetus to the work it has been continuing during the past six years.

Don't forget the dates—April 21 and 22.

### Make Hotel Reservations Early

Members of the Kansas Medical Assistants' Society who plan to attend the state meeting April 21 and 22 are urged to make reservations immediately. Wichita hotels are crowded, but it is thought that accommodations will be available for all. Write the hotel of your choice today.

### Fellowships in Medical Research

Acting as agent for various national societies, the National Research Council is offering additional fellowships which are available to newly separated medical department officers holding M.D. or Ph.D. degrees. These fellowships are in the fields of cancer research and anesthesiology.

### Fort Sam Houston Medical Center

Fort Sam Houston, Texas, will become an important Army medical center in March when medical activities formerly carried out at Carlisle Barracks, Pennsylvania, and at Fort Lewis, Washington, are transferred there, according to an announcement made recently by Major General Norman T. Kirk, Surgeon General of the Army. Concentration of the medical department schools and courses at the new center will represent a saving in transportation of trainees from one school to another. A basic medical department officers' course of approximately 1,100 newly-commissioned officers will be in continuous operation.

### Grants for Cardio-vascular Study

Grants totalling \$126,000 to be used for research into the causes of cardio-vascular diseases have been made to the medical schools of six universities by the Life Insurance Medical Research Fund, it was announced recently by M. Albert Linton, chairman of the fund.

During the next year the fund will have \$500,000 available for existing research projects in the field of heart and arterial diseases and for support of younger research fellows who, without that support, would be lost to the medical research field.



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### Regulation on Sugar Applications

Because of a deluge of certifications from doctors requesting additional sugar for various types of illness, the district food rationing officer, Mr. R. S. Fanestil of Wichita, has asked the Journal to give publicity to the ruling under which the OPA makes decisions on these requests. The National Research Council has sent the following release to OPA offices:

The National Research Council has recommended that no sugar, in excess of the amount of the regular consumer ration, is needed. In the opinion of the subcommittee on medical food requirements, additional rationed sugar, beyond the 15 pounds per capita per year now allocated under current rationing regulations, is not essential in the treatment of any disease, because unrationed sources of carbohydrates, including syrups, preserves and processed fruits and juices, are now readily available to provide a source not only of readily assimilable carbohydrates but also a wide range of palatable substances calculated to appeal to the palates of individuals, sick and convalescent, whose appetites have been impaired by illness."

For many months local rationing boards have been allocating supplemental sugar on the basis of medical certifications, and the procedure has now been changed to provide action on such requests at the district office only.

The co-operation of Kansas physicians is requested in this matter and it is urged that medical certifications be issued only in cases of necessity. The OPA, reports Mr. Fanestil, wishes to be as lenient as possible but feels that medical certifications for cases of senility, debility, etc., are not justified.

### VA Making Appointments

Managers of Veterans' Administration regional offices and hospitals have been authorized by the central office at Washington to make temporary appointments of doctors and dentists to full grade, B. C. Moore, deputy administrator of the St. Louis branch office, announced recently.

This grade will enable physicians to go to work immediately in VA hospitals, clinics and offices at a salary of from \$5,180 to \$6,020 a year as assistants to the chief of service or section. They will be given a preference as to location insofar as possible in the area. Interviews are conducted in any VA regional office or hospital in Kansas, Missouri, Oklahoma or Arkansas.

To qualify for these full grade positions a doctor must be a citizen of the United States and a graduate of a school of medicine approved by the administrator of veterans' affairs, and he must be licensed to practice as a physician in a state or territory of the United States.

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One Week Surgery Colon and Rectum starting March 18 and April 29.

One Week Course Thoracic Surgery starting March 11, April 22.

**GYNECOLOGY**—Two Weeks Intensive Course starting April 22, May 20.  
One Week Personal Course in Vaginal Approach to Pelvic Surgery March 18 and April 15.

**OBSTETRICS**—Two Weeks Intensive Course starting April 8 and May 6.

**MEDICINE**—Two Weeks Intensive Course starting April 8.

**ELECTROCARDIOGRAPHY & HEART DISEASE**—Two Weeks Intensive Course starting August 5.

**GASTROSCOPY & GASTROENTEROLOGY**—Two Weeks Personal Course April 22.

**DERMATOLOGY & SYPHILIOLOGY**—Two Weeks Course starting April 8.

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Volume XLVII

APRIL, 1946

Number 4

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*Greetings*

The Sedgwick County Medical Society is afforded the distinct honor of being host to the Kansas Medical Society during its 87th annual session. We take great pride in this privilege and wish to extend to our guests, to the members of the Kansas Medical Society and to the Auxiliary our most cordial welcome.

After a lapse of several years during which conventions were prohibited, this first post-war session gives to the Sedgwick County Medical Society the opportunity of presenting a program of greater than usual interest. We are proud to present the distinguished guests who will speak for the scientific assemblies. Social events have been planned to provide relaxation and an opportunity to visit with friends.

Every effort has been made to arrange for housing facilities for all members and guests. We are now confident that reservations can be obtained for everyone wishing to attend and request all who have not succeeded in making reservations to correspond with our Executive Office, 1003 Schweiter Building, Wichita, Kansas.

The Sedgwick County Medical Society is at your service during the week of April 22-25. We sincerely hope that your visit on this occasion will be profitable and pleasant and pledge that our every effort will be directed toward that end.

JOHN L. KLEINHEKSEL, M.D.,

*President, Sedgwick County Medical Society.*

## *Guest Speakers*



MATHER CLEVELAND, M.D.

*New York, New York*

Graduate, College of Physicians and Surgeons, Columbia, 1915; Attending Orthopedic Surgeon, St. Luke's Hospital; Diplomate, American Board of Orthopedic Surgery; Fellow, American College of Surgeons; Member, American Academy of Orthopedic Surgeons, American Orthopedic Association. Colonel, M.C., A.U.S., 1942-1945.

Specialty: Orthopedics.



WALLACE EDGAR HERRELL, M.D.

*Rochester, Minnesota*

Graduate, University of Virginia, 1933; Assistant Professor of Medicine, Mayo Foundation; Consultant in Medicine, Mayo Clinic; Fellow, American College of Physicians; Member, American Federation for Clinical Research, American Therapeutic Society, Central Society for Clinical Research.

Specialty: Internal Medicine.

**HOWARD ROMMEL HILDRETH, M.D.***St. Louis, Missouri*

Graduate, Washington University School of Medicine, 1928; Diplomate, American Board of Ophthalmology; Member, American Academy of Ophthalmology and Otolaryngology, Association for Research in Ophthalmology.

Specialty: Ophthalmology.

**ANDREW CONWAY IVY, M.D.***Chicago, Illinois*

Graduate, Rush Medical College, 1922; Head of Department of Physiology, Northwestern University Medical School; Former Chairman of Section on Pathology and Physiology of American Medical Association; Past President, American Physiological Society, American Gastroenterological Association; Scientific Director, Naval Medical Research Institute, 1942-1943.

Specialty: Internal Medicine.





FRANCIS LOEFFLER LEDERER, M.D.

*Chicago, Illinois*

Graduate, Rush Medical College, 1921; Professor and Head of Department of Laryngology, Rhinology and Otology, University of Illinois College of Medicine; Director of Education (Otolaryngology), Illinois Eye and Ear Infirmary; Diplomate, American Board of Otolaryngology; Fellow, American College of Surgeons, American College of Chest Physicians; Member, American Academy of Ophthalmology and Otolaryngology; Captain, M.C., U.S.N.R., 1942-1946.

Specialty: Otolaryngology.



MITCHELL IRVING RUBIN, M.D.

*Buffalo, New York*

Graduate, Medical College of the State of South Carolina, 1925; Professor of Pediatrics, University of Buffalo; Pediatrician-in-chief, Children's Hospital of Buffalo; Former Associate Professor of Clinical Pediatrics, University of Pennsylvania; Diplomate, American Board of Pediatrics; Member, American Pediatric Society.

Special: Pediatrics.

**LOWELL DELFORD SNORF, M.D.***Evanston, Illinois*

Graduate, Rush Medical College, 1915; Associate Professor of Medicine, Northwestern University; Chief of Department of Medicine, Evanston Hospital; Diplomate, American Board of Internal Medicine; Fellow, American College of Physicians; Member American Gastroenterologic Association.

Specialty: Internal Medicine.

**MAURICE NIHILL WALSH, M.D.***Minneapolis, Minnesota*

Graduate, Detroit College of Medicine and Surgery, 1931; Associate Professor, University of Minnesota Graduate School; Former Consultant in Neuropsychiatry, Mayo Clinic; Diplomate, American Board of Psychiatry and Neurology; Member, Central Neuropsychiatric Association; Lieutenant Colonel, M.C., A.U.S., 1942-1945.

Specialty: Psychiatry and Neurology.





JOHN MACMASTER WAUGH, M.D.

*Rochester, Minnesota*

Graduate, Rush Medical College, 1932; Associate Professor of Surgery, Mayo Foundation, University of Minnesota; Diplomate, American Board of Surgery; Fellow, American College of Surgeons, Western Surgical Association, Central Surgical Association, Central Association of Obstetricians and Gynecologists.

Specialty: Surgery.



JAMES ROBERT WILLSON, M.D.

*Chicago, Illinois*

Graduate, University of Michigan School of Medicine, 1937; Assistant Professor, Obstetrics and Gynecology, University of Chicago. Attending Obstetrician and Gynecologist, Chicago Lying-in-Hospital.

Specialty: Obstetrics and Gynecology.

MAJOR GENERAL PAUL RAMSEY HAWLEY, M.C., U.S.A.

*Washington, D. C.*

Acting Surgeon General, Medical Corps, Veterans' Administration, under whose capable leadership and direction a new era in the medical care of veterans is now in the making. Chief Surgeon of The European Theater of Operations during the war.



COLONEL JAMES CLAYTON HARDING,  
M.C., U.S.A.

*Washington, D. C.*

In charge of out-patient care for the Veterans' Administration. Col. Harding is directly responsible for the operation of such programs as the Kansas Medical Society plan for veterans' medical care.



# Schedule of Events

## 87TH ANNUAL SESSION

Wichita, April 22, 23, 24, 25, 1946

### MONDAY, APRIL 22

#### TOURNAMENT KANSAS MEDICAL GOLFING ASSOCIATION

*Westlinks Golf Club (5828 Maple, Highway 54)*

10:00 A. M. Practice Rounds

1:00 P. M. Competitive Golfing

#### TOURNAMENT KANSAS MEDICAL SKEET AND TRAPSHOOTING ASSOCIATION

*Wichita Gun Club (Three miles west on Highway 54)*

10:00 A. M. Practice Shooting

1:30 P. M. Competitive Shooting

#### TOURNAMENT BANQUET

7:00 P. M. Broadview Hotel

Awarding of Prizes for Golf and Skeet Shoot  
Election of Officers

#### HOUSE OF DELEGATES

8:30 P. M. Allis Hotel—Empire Room

### TUESDAY MORNING, APRIL 23

8:30 A. M. Registration

*North Entrance of Forum—Open 8:30 A. M. to 6:00 P. M.*

Opening of Scientific and Technical Exhibits  
*Rose Room, Forum*

9:00 A. M. Showing of Motion Picture

#### FIRST GENERAL SESSION

*Arcadia Theater, Forum*

Presiding: John L. Kleinheksel, M.D., Wichita, Kansas

9:30 A. M. ACUTE GLOMERULONEPHRITIS IN CHILDHOOD

Mitchell I. Rubin, M.D., Buffalo, New York

Death in acute glomerulonephritis usually results from one of three complications occurring early in the disease: cardiac failure, renal failure, hypertensive encephalopathy. These complications can be anticipated by employing a few simple clinical guides, and when treatment is instituted early they may be prevented. An understanding of the basic physiologic mechanisms involved in the production of the complications leads to a rational form of therapy for the patient with this disease.

The treatment of acute glomerulonephritis has been simplified and a schedule of treatment based on physiological concepts will be presented.

In order to prognosticate the outcome of nephritis certain laboratory tests may be used in assessing recovery. A comparison of the value of these various tests will be presented and a survey of the ultimate prognosis of acute glomerulonephritis given.

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

10:15 A. M. JAUNDICE: THE DIFFERENTIAL THERAPEUTIC DIAGNOSIS

Andrew C. Ivy, M.D., Chicago, Illinois

When the physician sees a patient with jaundice, he must determine which the condition causing jaundice requires, surgical or medical management. An attempt will be made to point out how certain tests of liver function may be used in relation to the clinical findings to reduce the error in the differential diagnosis.

11:00 A. M. INTERMISSION

11:15 A. M. CARCINOMA OF THE RECTUM AND RECTOSIGMOID: CHOICE OF OPERATIVE PROCEDURE WITH REFERENCE TO PRESERVATION OF THE SPHINCTERS

John M. Waugh, M.D., Rochester, Minnesota

In recent years it has become possible in an increasing number of patients with carcinoma of the rectosigmoid and rectum to carry out a radical curative operation with preservation of the sphincters. In many instances this can be accomplished as a one-stage procedure without a previous or simultaneous temporary colostomy. With proper pre-operative preparation and a knowledge of the indications for these respective procedures, such operations can be executed with as low a mortality rate as that accompanying one-stage combined abdomino-perineal resection with permanent colostomy.

Recent investigation in regard to the retrograde spread of carcinoma justifies preservation of the sphincters when the lesion involves the rectosigmoid or the ampullary portion of the rectum. When the lower rectum or anus is the primary site of the carcinoma, whether the levator muscles are grossly involved or not, wide excision of the perianal skin, subcutaneous tissue, sphincters and levators should be an integral part of the resection.

12:15 P. M. ROUND TABLE LUNCHEONS

KANSAS HEART SOCIETY—*Lassen Hotel*

Business Meeting

MEDICINE—*Lassen Hotel, Grill*

Guest Speaker: Andrew C. Ivy, M.D., Chicago, Illinois

Discussion Leader: Sloan Wilson, M.D., University of Kansas

Presiding: J. B. Nanninga, M.D., Newton, Kansas

SURGERY—*Allis Hotel, Empire Room*

Guest Speaker: John M. Waugh, M.D., Rochester, Minnesota

Discussion Leader: Thomas G. Orr, M.D., University of Kansas

Presiding: N. E. Melencamp, M.D., Dodge City, Kansas

PEDIATRICS—*Broadview Hotel*

Guest Speaker: Mitchell I. Rubin, M.D., Buffalo, New York

Discussion Leader: H. C. Miller, M.D., University of Kansas

Presiding: B. I. Krehbiel, M.D., Topeka, Kansas

EYE, EAR, NOSE AND THROAT—*Broadview Hotel*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

Francis L. Lederer, M.D., Chicago, Illinois

Discussion Leader: LaVerne B. Spake, M.D., University of Kansas

Presiding: W. W. Reed, M.D., Topeka, Kansas

## TUESDAY AFTERNOON, APRIL 23

## SECOND GENERAL SESSION

*Arcadia Theater, Forum*

Presiding: R. R. Cave, M.D., Manhattan, Kansas

## 2:00 P. M. PRESIDENT'S ADDRESS

W. P. Callahan, M.D., Wichita, Kansas

## 2:20 P. M. THE YEAR AHEAD

W. M. Mills, M.D., Topeka, Kansas

## 2:30 P. M. THE DIAGNOSTIC INTERPRETATION OF VISCERAL PAIN

Andrew C. Ivy, M.D., Chicago, Illinois

The newer knowledge of visceral pain will be presented. The various types of pain which occur in visceral disease will be explained and their diagnostic significance will be indicated and illustrated by cases and clinical data.

## 3:20 P. M. PYURIA, ITS CLINICAL SIGNIFICANCE IN CHILDREN

Mitchell I. Rubin, M.D., Buffalo, New York

The source of pus cells in the urine of children is often outside of the urinary tract. It is therefore important to determine the origin of the pus cells. In most cases of urinary tract infection the source of the pus is the kidney parenchyma—pyelonephritis. Pyelonephritis is not a simple disease of childhood as it has a high tendency to recurrences and chronicity and often leads eventually to renal insufficiency. The chief underlying factor in this tendency to recurrence is malformations of the urinary tract with obstruction to urine flow. Surgical treatment of these anomalies has resulted in considerable recovery of kidney function even late in the disease, and should be employed even though the patient may appear hopelessly ill. There is a large group of children whose illnesses result from various anomalies of the urinary tract which produce urine stasis, with and without infection, and yet have no symptoms directly related to the urinary tract—so called "silent kidney." These syndromes will be discussed.

The commonest cause of persistent hypertension in children is pyelonephritis. There are several instances where hypertension was associated with unilateral kidney disease, and where nephrectomy resulted in the restoration of the blood pressure to normal levels. The relationship of hypertension to vascular lesions in the kidney will be presented.

Because of the serious import of urinary tract infections in childhood these children deserve careful study. The management of such a patient will be discussed.

## 4:10 P. M. INTERMISSION

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

## CONVOCATION OF GENERAL AND E.N.T. SESSIONS

Presiding: LaVerne B. Spake, M.D., University of Kansas

## 4:30 P. M. CONSERVATION OF RESIDUAL HEARING

Francis L. Lederer, M.D., Chicago, Illinois

The recent war has prominently brought to fore the urgent and essential need of the adequate treatment of aural disabilities. It is estimated that 16 per cent of our population is hard of hearing; that four out of every 1,000 of our 18-to 19-year-olds were rejected by selective service because of defective ears; that 40 per cent of the hard of hearing service men who required rehabilitation by the Army and Navy for incapacitating hearing losses suffered their disabilities prior to entering the service and the thousands of others who were subjected to acoustic trauma add to the figures of our hard of hearing in this country. The field is extensive enough to warrant concerted action at considerable expense of time and energy by all interested groups. There is sufficient foundation of institutional and military experience with treatment of large numbers of hard of hearing persons to suggest a pattern and a methodology that can be translated efficiently into present needs under the leadership of American otologists. A constructive program of physico-psychosocial treatment of the hard of hearing is offered for consideration.

6:30 P. M. DINNER FOR WOMEN PHYSICIANS—*Innes Tea Room*

7:00 P. M. STAG AND SMOKER (Place to be announced)

## WEDNESDAY MORNING, APRIL 24

## 8:30 A. M. REGISTRATION

*North Entrance of Forum*—Open 8:30 A.M. to 6:00 P.M.  
Scientific and Technical Exhibits  
*Rose Room, Forum*

## 9:00 A. M. SHOWING OF MOTION PICTURE

## THIRD GENERAL SESSION

*Arcadia Theater, Forum*  
Presiding: G. E. Paine, M.D., Hutchinson, Kansas

## 9:00 A. M. PRINCIPLES OF TREATMENT IN PRE-ECLAMPSIA AND ECLAMPSIA

J. Robert Willson, M.D., Chicago, Illinois

In contrast to essential hypertension and nephritis with a superimposed pregnancy, pre-eclampsia and eclampsia are conditions occurring only in the pregnant patient, and usually during the last half of the period of gestation. With our present knowledge, we are unable to prevent the onset of pre-eclampsia but with early diagnosis and judicious treatment we may modify its course and prevent the development of the eclamptic state. The earliest sign of pre-eclampsia is an unusual gain in weight, indicative of abnormal fluid retention; proteinuria and hypertension appear later. The early institution of treatment directed toward maintenance of normal renal function and reversal of abnormal fluid exchange will in most instances prevent the development of severe pre-eclampsia and eclampsia. The treatment of convulsive toxemia resolves itself principally around restoration of renal function, control of convulsions and delivery at the optimum time.

## 9:50 A. M. CLINICAL USE OF PENICILLIN

Wallace E. Herrell, M.D., Rochester, Minnesota

This presentation deals with a summary of the present day knowledge of the clinical uses and limitations of penicillin. Dosage, methods of administration and toxicity are discussed.

## 10:40 A. M. INTERMISSION

## 11:00 A. M. EXTERNAL SKELETAL FIXATION OF FRACTURES

Mather Cleveland, M.D., New York, New York

This will be a discussion of certain complications which occur following external fixation of fractures. Some of these cases will be from civilian practice and some from the Army.

## 12:15 P. M. ROUND TABLE LUNCHEONS

MEDICINE—Lassen Hotel, Grill

Guest Speaker: Wallace E. Herrell, M.D., Rochester, Minnesota  
Discussion Leader: Max S. Allen, M.D., University of Kansas  
Presiding: F. A. Trump, M.D., Ottawa, Kansas

OBSTETRICS AND GYNECOLOGY—Allis Hotel, Empire Room

Guest Speaker: J. Robert Willson, M.D., Chicago, Illinois  
Discussion Leader: H. M. Floersch, M.D., University of Kansas  
Presiding: Porter Brown, M.D., Salina, Kansas

KANSAS SOCIETY OF OBSTETRICS AND GYNECOLOGY

Meeting following above luncheon

FRACTURES—Broadview Hotel

Guest Speaker: Mather Cleveland, M.D., New York, New York  
Discussion Leader: J. B. Weaver, M.D., University of Kansas  
Presiding: C. H. Benage, M.D., Pittsburg, Kansas

EYE, EAR, NOSE AND THROAT—Broadview Hotel

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri  
Francis L. Lederer, M.D., Chicago, Illinois  
Discussion Leaders: J. A. Billingsley, M.D., and LaVerne B. Spake, M.D.,  
University of Kansas  
Presiding: Louis R. Haas, M.D., Pittsburg, Kansas

## WEDNESDAY AFTERNOON, APRIL 24

## FOURTH GENERAL SESSION

*Arcadia Theater, Forum*

Presiding: A. A. Sprong, M.D., Sterling, Kansas

## 2:00 P. M. INFLUENCE OF COMPLICATIONS ON THE MANAGEMENT OF PEPTIC ULCER

Lowell D. Snorf, M.D., Evanston, Illinois

The management of the simple uncomplicated peptic ulcer is not difficult. The complications that arise from this simple lesion result in certain anatomic and physiologic changes that alter the function of the stomach giving rise to numerous complications and resulting in the typical chronic disorders with which the patient with peptic ulcer is commonly afflicted.

Special emphasis will be directed to obstructive lesions, perforation, excessive continued secretion and hemorrhage. These complications will be dealt with from the standpoint of recognition and differential diagnosis and treatment. Indications for medical and surgical treatments will be discussed.

## 2:50 P. M. VAGINAL HYSTERECTOMY: INDICATIONS AND CONTRA-INDICATIONS

John M. Waugh, M.D., Rochester, Minnesota

It is imperative for the gynecologic surgeon or the general surgeon doing gynecologic surgery to be well versed in both the abdominal and the vaginal route of performing hysterectomy. These methods are not antagonistic, but are very definitely supplementary. Certain patients are advantageously operated on by one method, whereas the other method is indicated for another group. If a surgeon has only one method at his disposal he is frequently prejudiced in favor of this method and all patients are treated in the same manner, no doubt in certain instances with increased risk or an inferior end result, whereas with both methods at his disposal he can weigh the advantages of each and choose that best suited for the individual patient.

## 3:40 P. M. INTERMISSION

## 4:00 P. M. CLINICAL USE OF STREPTOMYCIN

Wallace E. Herrell, M.D., Rochester, Minnesota

This discussion concerns itself with the development of streptomycin, the antibiotic agent described by Schatz, Bugie and Waksman. What is known concerning its pharmacologic behavior and its possible toxic effects as well as methods of administration are discussed. Its possible clinical usefulness and limitations are also presented.

7:00 P. M. ANNUAL BANQUET—*Broadview Hotel, Ballroom*

## MEDICINE IN CURRENT FEDERAL LEGISLATION

Rev. Alphonse M. Schwitalla, S.J., Ph.D., St. Louis, Missouri

10:00 P. M. to 1:00 A. M. DANCE—*Broadview Hotel*

## THURSDAY MORNING, APRIL 25

## 8:30 A. M. REGISTRATION

*North Entrance of Forum*—Open 8:30 A. M. to 4:00 P. M.

Scientific and Technical Exhibits

*Rose Room, Forum*

## 9:00 A. M. SHOWING OF MOTION PICTURE

## FIFTH GENERAL SESSION

*Arcadia Theater, Forum*

Presiding: H. E. Snyder, M.D., Winfield, Kansas

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

9:00 A. M. NEUROPSYCHIATRIC SERVICES FOR THE VETERAN  
Karl Menninger, M.D., Topeka, Kansas

9:45 A. M. PSYCHOSOMATIC PROBLEMS OF EVERYDAY MEDICAL PRACTICE

Maurice N. Walsh, M.D., Minneapolis, Minnesota

It has been estimated that one-third of all patients who consult physicians have symptoms which are of psychic origin, another third have symptoms both of organic and psychic origin, and only one-third have symptoms of purely organic origin. The stresses set up by conflicts in the emotional life produce anxiety which may give rise to a wide variety of symptoms. The characteristics and meaning of certain of the more common psychosomatic symptoms and syndromes will be discussed. The general practitioner is best situated to practice psychosomatic medicine, since he can observe the patient in his family and social situation, often over long periods of time. However, some knowledge of normal human personality development is necessary for best results. Certain practical applications of this knowledge will be briefly brought out. As in all of medicine, proper treatment can be given only if the diagnosis arrived at is correct, and in psychosomatic problems this involves a formulation of the basic dynamic forces which have produced the patient's symptoms.

10:30 A. M. THE TREATMENT OF BENIGN MENOPAUSAL BLEEDING  
J. Robert Willson, M.D., Chicago, Illinois

Uterine bleeding with a proven non-malignant etiology during the menopausal period may be controlled either by hysterectomy or irradiation. Each method has its contraindications as well as its indications and before a program of therapy is outlined for a particular patient the advantages of each should be considered. The morbidity and mortality rates in properly selected irradiated cases are low and the complications from x-ray or radium therapy may be kept at a minimum by careful selection of cases and by use of the method by individuals who are thoroughly familiar with its effects.

11:15 A. M. CHRONIC ULCERATIVE COLITIS  
Lowell D. Snorf, M.D., Evanston, Illinois

There will be a discussion of the etiology, symptomatology, pathology and treatment of chronic ulcerative colitis. Particular stress will be laid on the early recognition of these lesions of this disorder and attention directed to the medical management. Color photographs will be shown, made directly through the sigmoidoscope and also microscopic and macroscopic pathologic appearances of the lesions in the colon.

12:15 P. M. ROUND TABLE LUNCHEONS

OBSTETRICS AND GYNECOLOGY—Allis Hotel, Empire Room  
Guest Speaker: J. Robert Willson, M.D., Chicago, Illinois

Discussion Leader: L. A. Calkins, M.D., University of Kansas

Presiding: William L. Pratt, M.D., Leavenworth, Kansas

PSYCHOSOMATIC MEDICINE—Lassen Hotel

Guest Speakers: Maurice N. Walsh, M.D., Minneapolis, Minnesota  
Lowell D. Snorf, M.D., Evanston, Illinois

Discussion Leader: Karl Menninger, M.D., Topeka, Kansas

Presiding: William H. Algie, M.D., Kansas City, Kansas

FRACTURES—Broadview Hotel

Guest Speaker: Mather Cleveland, M.D., New York, New York

Discussion Leader: Frank Dixon, M.D., University of Kansas

Presiding: M. J. Renner, M.D., Goodland, Kansas

## THURSDAY AFTERNOON, APRIL 25

### SIXTH GENERAL SESSION

*Arcadia Theater, Forum*

Presiding: John M. Porter, M.D., Concordia, Kansas

#### 2:00 P. M. THE PRINCIPLES OF MANAGEMENT OF PSYCHOSOMATIC DISORDERS

Maurice N. Walsh, M.D., Minneapolis, Minnesota

After a psychosomatic disorder has been diagnosed many physicians feel a sense of helplessness in selecting and carrying out proper treatment. As in the case of surgery, there is a major and a minor psychotherapy, and the latter can be successfully practiced by any physician familiar with certain basic principles. Major psychotherapy is essential in the psychoses and severe neuroses and must be carried out by specialists. However, there exists a wide variety of minor psychotherapeutic techniques available for use by the general practitioner in his office and hospital practice. Selection of the methods to be employed will depend upon the type of problem presented, as well as the intelligence and social situation of the patient. Certain minor psychotherapeutic techniques will be discussed and indications for their use given. The patient must never be permitted to feel that the physician believes that his illness is imaginary or disgraceful in some way, and a rational explanation for the symptoms must be given. For successful application of these principles it is necessary that the physician prepare himself by further study.

#### 2:45 P. M. INTERMISSION

#### 3:00 P. M. PROBLEMS OF INTERTROCHANTERIC FRACTURES OF THE FEMUR

Mather Cleveland, M.D., New York, New York

This paper will be a brief presentation of the problem of intertrochanteric fractures of the femur, which is an injury associated with the aged. These are a group of people who are an average of 11 to 12 years older than those who fracture the neck of the femur. It is really a problem of geriatrics as well as a fracture treatment. We have, for the past four years, been treating these patients with internal fixation and believe that it offers the best opportunity to return these elderly people to a relatively normal life.

#### 4:00 P. M. HOUSE OF DELEGATES

*Allis Hotel, Aviation Room*

### Committee Chairmen

- J. E. Wolfe, M.D., General Chairman.
- J. S. Reifsneider, M.D., Scientific Program.
- J. L. Beaver, M.D., Commercial Exhibits.
- A. E. Hiebert, M.D., Scientific Exhibits.
- B. P. Meeker, M.D., Arrangements.
- A. L. Ashmore, M.D., Reception.
- R. H. Maxwell, M.D., Publicity.
- H. R. Hodson, M.D., Entertainment
- C. C. Brown, M.D., Woman's Auxiliary.

# *Eye, Ear, Nose and Throat Section*

TUESDAY, APRIL 23

8:30 A. M. REGISTRATION

*North Entrance of Forum*—Open 8:30 A. M. to 6:00 P. M.  
All meetings in the Eye, Ear, Nose and Throat Section Room  
Presiding: Lester A. Latimer, M.D., Alexander, Kansas

9:30 A. M. TEAR SAC SURGERY

H. Rommel Hildreth, M.D., St. Louis, Missouri

In older people with chronic dacryocystitis the best method of curing the condition is extirpation of the sac. This is especially true if an intraocular operation is pending. Two landmarks, the anterior lacrimal crest and the medial canthal ligament, are helpful in removing the sac. To avoid bleeding the incision should be well off the side of the nose so as to not cut the angular vein. Block anesthesia is important.

10:30 A. M. INTERMISSION

11:00 A. M. THE OTOLOGIST'S ROLE IN REHABILITATION OF THE HARD OF HEARING ADULT

Francis L. Lederer, M.D., Chicago, Illinois

Efforts for the hard of hearing adult deviate sharply from the training to the congenitally deaf, the former having their deafness superimposed upon mature habits of communication. Speech memory of recently deafened adults calls for different educational modalities. Based upon the experience and study of 3,000 persons, the etiologic factors, associated symptoms, reliability of functional tests of hearing and quantified measurements of acuity will be discussed. The relation between medical and non-medical aspects in the rehabilitative process and the performance of hearing aids are of special interest. It seems plausible and feasible to translate the experience of the military services in dealing with the deaf in civilian life, and thus make definite progress toward the solution of a problem which requires concerted action and has received but meager attention.

12:15 P. M. ROUND TABLE LUNCHEON—Broadview Hotel

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

Francis L. Lederer, M.D., Chicago, Illinois

Discussion Leader: LaVerne B. Spake, M.D., University of Kansas

Presiding: W. W. Reed, M.D., Topeka, Kansas

2:30 P. M. ORBITAL TUMORS

H. Rommel Hildreth, M.D., St. Louis, Missouri

Unilateral exophthalmus is often inflammatory in origin and usually secondary to intranasal disease. Such orbits seldom need surgical drainage nowadays. Of the non-inflammatory cases a malignancy is the most common cause. Many of these tumors are slow-growing; some are benign and can be removed safely. Exenteration is required for malignant growths.

3:30 P. M. INTERMISSION

CONVOCATION OF GENERAL AND E.E.N.T. SESSIONS

Arcadia Theater, Forum

Presiding: LaVerne B. Spake, M.D., University of Kansas

4:30 P. M. CONSERVATION OF RESIDUAL HEARING

Francis L. Lederer, M.D., Chicago, Illinois

See General Session Program for Summary of This Paper

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

**WEDNESDAY, APRIL 24****8:30 A. M. REGISTRATION**

*North Entrance of Forum*—Open 8:30 A. M. to 6:00 P.M.  
Presiding: E. N. Robertson, Sr., M.D., Concordia, Kansas

**9:30 A. M. MUSCLE SURGERY**

H. Rommel Hildreth, M.D., St. Louis, Missouri

Bilateral recession of the internal rectus muscles is a very satisfactory procedure for the correction of a great many of our strabismus patients. Hospitalization is short as is the entire convalescent period. Catgut sutures can be used in smaller children in closing the conjunctiva so that a minimum of post-operative care is necessary.

**10:30 A. M. INTERMISSION****11:00 A. M. EVALUATION OF EARLY SIGNS OF OTOGENIC COMPLICATIONS**

Francis L. Lederer, M.D., Chicago, Illinois

Complications of middle ear suppuration have so many symptoms in common that a diagnosis must be arrived at early enough to assure a better prognosis. The earliest signs and symptoms are to be emphasized for the reason that when recognized before they fully manifest, their control is within the possibility of cure. Otitis media is discussed as separate entities in children and adults because anatomic variations and physical characteristics made certain differences possible in their course and response to infection. The cardinal signs of intracranial extension will be analyzed and their significance interpreted. Chemotherapeutic restrictions and indications for surgical interference in acute and chronic otitis media will be presented with a discussion of the signs and symptoms most frequently observed.

**12:15 P. M. ROUND TABLE LUNCHEON—Broadview Hotel**

Guest Speakers: Francis L. Lederer, M.D., Chicago, Illinois

H. Rommel Hildreth, M.D., St. Louis, Missouri

Discussion Leaders: J. A. Billingsley, M.D., and LaVerne B. Spake, M.D.,  
University of Kansas

Presiding: Louis R. Haas, M.D., Pittsburg, Kansas

**2:00 P. M. INTRAOCULAR FOREIGN BODIES**

H. Rommel Hildreth, M.D., St. Louis, Missouri

The human eye does not tolerate intraocular foreign bodies. After x-ray localization the sclera should be opened at a point nearest the foreign body. If a traumatic cataract is present, the cataract may be extracted and then the foreign body removed through the same wound. The Burman Locator, a new piece of equipment, is a useful aid in this operation.

**3:00 P. M. INTERMISSION****4:00 P. M. PROBLEMS INVOLVED IN THE DIAGNOSIS AND TREATMENT OF MALIGNANCIES OF THE NASAL ACCESSORY SINUSES**

Francis L. Lederer, M.D., Chicago, Illinois

In the light of modern advances it is now possible to predict a more favorable prognosis for cancer of the nasal sinuses. Allied with early recognition of tumors of this site, is the combined attack of surgery, electrosurgery, x-ray and radium with a greater understanding than ever before. Diagnostic methods, pathologic considerations, symptomatology and treatment will be presented; illustrated by cases typifying the characteristics and management of nasal accessory sinus malignancy.

# *Round Table Luncheons*

## TUESDAY, APRIL 23

### KANSAS HEART SOCIETY—*Lassen Hotel*

Business Meeting

### MEDICINE—*Lassen Hotel, Grill*

Guest Speaker: Andrew C. Ivy, M.D., Chicago, Illinois

Discussion Leader: Sloan Wilson, M.D., University of Kansas

Presiding: J. B. Nanninga, M.D., Newton, Kansas

### SURGERY—*Allis Hotel, Empire Room*

Guest Speaker: John M. Waugh, M.D., Rochester, Minnesota

Discussion Leader: Thomas G. Orr, M.D., University of Kansas

Presiding: N. E. Melencamp, M.D., Dodge City, Kansas

### PEDIATRICS—*Broadview Hotel*

Guest Speaker: Mitchell I. Rubin, M.D., Buffalo, New York

Discussion Leader: H. C. Miller, M.D., University of Kansas

Presiding: B. I. Krehbiel, M.D., Topeka, Kansas

### EYE, EAR, NOSE AND THROAT—*Broadview Hotel*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

Francis L. Lederer, M.D., Chicago, Illinois

Discussion Leader: LaVerne B. Spake, M.D., University of Kansas

Presiding: W. W. Reed, M.D., Topeka, Kansas

## WEDNESDAY, APRIL 24

### MEDICINE—*Lassen Hotel, Grill*

Guest Speaker: Wallace E. Herrell, M.D., Rochester, Minnesota

Discussion Leader: Max S. Allen, M.D., University of Kansas

Presiding: F. A. Trump, M.D., Ottawa, Kansas

### OBSTETRICS AND GYNECOLOGY—*Allis Hotel, Empire Room*

Guest Speaker: J. Robert Willson, M.D., Chicago, Illinois

Discussion Leader: H. M. Floersch, M.D., University of Kansas

Presiding: Porter Brown, M.D., Salina, Kansas

### KANSAS SOCIETY OF OBSTETRICS AND GYNECOLOGY Meeting following above luncheon

### FRACTURES—*Broadview Hotel*

Guest Speaker: Mather Cleveland, M.D., New York, New York

Discussion Leader: J. B. Weaver, M.D., University of Kansas

Presiding: C. H. Benage, M.D., Pittsburg, Kansas

### EYE, EAR, NOSE AND THROAT—*Broadview Hotel*

Guest Speakers: H. Rommel Hildreth, M.D., St. Louis, Missouri

Francis L. Lederer, M.D., Chicago, Illinois

Discussion Leaders: J. A. Billingsley, M.D., and LaVerne B. Spake, M.D.,  
University of Kansas

Presiding: Louis R. Haas, M.D., Pittsburg, Kansas.

## THURSDAY, APRIL 25

### OBSTETRICS AND GYNECOLOGY—*Allis Hotel, Empire Room*

Guest Speaker: J. Robert Willson, M.D., Chicago, Illinois

Discussion Leader: L. A. Calkins, M.D., University of Kansas

Presiding: William L. Pratt, M.D., Leavenworth, Kansas

### PSYCHOSOMATIC MEDICINE—*Lassen Hotel*

Guest Speakers: Maurice N. Walsh, M.D., Minneapolis, Minnesota  
Lowell D. Snorf, M.D., Evanston, Illinois

Discussion Leader: Karl Menninger, M.D., Topeka, Kansas

Presiding: William H. Algie, M.D., Kansas City, Kansas

### FRACTURES—*Broadview Hotel*

Guest Speaker: Mather Cleveland, M.D., New York, New York

Discussion Leader: Frank Dixon, M.D., University of Kansas

Presiding: M. J. Renner, M.D., Goodland, Kansas

# *The Annual Banquet*

WEDNESDAY, APRIL 24, 7:00 P. M.

Roof Garden, Broadview Hotel

MUSIC

ENTERTAINMENT

INTRODUCTION OF HONORED GUESTS

MEDICINE IN CURRENT FEDERAL LEGISLATION

The Reverend Alphonse M. Schwitalla, S. J., Ph. D.

DANCING—10:00 P. M. to 1:00 A. M.

REV. ALPHONSE M. SCHWITALLA, S.J.,  
PH.D., LLD., SC.D.

Dean, St. Louis University School of Medicine; Professor of Biology and Head of Department, St. Louis University; President, Catholic Hospital Association of United States and Canada; Associate Fellow, American Medical Association; Member, Advisory Committee, Council on Medical Education and Hospitals of American Medical Association.



# *Scientific Exhibits*

## CANCER DISTINCTION IN GENERAL PRACTICE

American Cancer Society, Sarah Lou Torey in Charge

## CORONARY ARTERIAL DISEASES

Donald McMinimy, M.D., and F. J. McEwen, M.D., Department of Cardiology and Pathology, St. Francis, Wichita, Kansas

## DIAGNOSIS OF BREAST TUMORS DURING OPERATION

Cramer Reed, M.D., and A. C. Hellwig, M.D., Department of Pathology, St. Francis Hospital, Wichita, Kansas

## EPILEPTICS, CHANGE IN ELECTROCARDIOGRAM UNDER TREATMENT OF DILATIN SODIUM

O. E. Stevenson, M.D., State Hospital for Epileptics, Parsons, Kansas

## GERIATRICS

William B. Kountz, M.D., Washington University, St. Louis, Missouri

## INTRAVENOUS PYELOGRAPHY AS A ROUTINE EXAMINATION

A. F. Rossitto, M.D., Wichita Hospital, Wichita, Kansas

## KANSAS STATE BOARD OF HEALTH

## MYCOLOGY

J. V. Van Cleve, M.D., and J. P. Berger, M.D., Wichita, Kansas

## PRACTICAL AND PROFITABLE PROCEDURE FOR BLOOD EXAMINATIONS SUITABLE TO THE PRIVATE PRACTITIONER

Thomas P. Haslam, M.D., Council Grove, Kansas

## SERIES OF X-RAYS FOLLOWING PROGRESS OF TUBERCULOSIS PATIENTS IN SANITORIUM AND OTHER INTERESTING CASES

C. F. Taylor, M.D., Norton, Kansas

## SKIN CANCER

M. Trueheart, M.D., Sterling, Kansas

## STUDIES IN UTERO-SALPINGOGRAPHY

E. L. Cooper, M.D., Wichita, Kansas

## TROPICAL DISEASES: USE AND ABUSE OF BARBITURATES, USE AND ABUSE OF SULPHONAMIDES, HEART AND RESPIRATION, CANCER, AND BURNS

American Medical Association

## VOCATIONAL REHABILITATION

Vocational Rehabilitation Division, Harry M. Dawdy, Director

## X-RAY STUDIES OF INTERESTING CHEST CONDITIONS

A. L. Ashmore, M.D., Wichita, Kansas

## X-RAY STUDIES OF RELATIONS OF THE ORGANS, ANATOMICAL STUDIES

General Electric, Chicago, Illinois

## TITLE NOT GIVEN

Warren F. Bernstorf, M.D., Winfield, Kansas

TICKETS FOR ALL SPECIAL EVENTS AVAILABLE AT TIME OF REGISTRATION

## *Retiring President and President-elect*



WILLIAM PAUL CALLAHAN, M.D.  
*Retiring President*

One year ago the Journal spoke of Dr. Callahan's dynamic qualities of leadership, his interest in the medical profession and his broad understanding of its problems. At that time confidence was expressed toward the work that would be accomplished during the coming year.

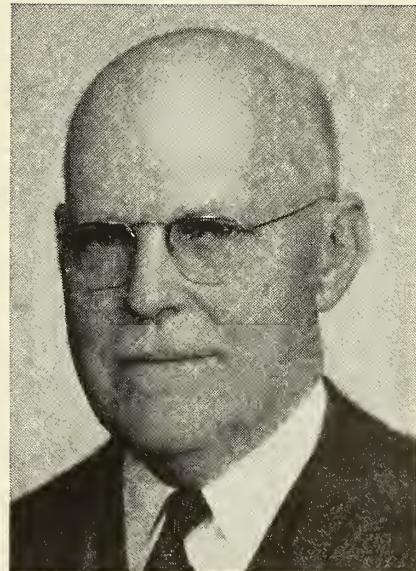
Every anticipation has been more than fulfilled during the remarkable year the medical society has experienced under Dr. Callahan's leadership. During his administration the war came to a conclusion. Areas critically in need of physicians were supplied with medical care. The postgraduate fund became a working reality during the past year, as did Kansas Physicians' Service. Not content with these achievements, Dr. Callahan personally arranged with the Veterans' Administration an agreement whereby a great portion of medical care for veterans can be rendered by the private physician. This also has become effective during Dr. Callahan's term of office.

Thanks to Dr. Callahan's limitless energy and to his accurate judgment, the Society is stronger and of greater service than it was before.

The Kansas Medical Society will be directed during the coming year by Dr. William Merrill Mills of Topeka. At a time when medicine faces numerous distressing situations from without, when pressure from self-centered lay groups is more volatile than ever before, when programs within the Society will need stimulation and guidance, the Society is fortunate to have Dr. Mills become president.

Dr. Mills, through many years of participation in all phases of Society activities, is entirely familiar with the responsibility he assumes. For 12 years he has been editor of the Journal of the Kansas Medical Society. He has served as councilor for the fourth district and has always participated actively in committee assignments.

Dr. Mills' talent for discernment and his rare sound judgment inspire confidence. These qualities have long been reflected in decisions of the Council and the House of Delegates and portend for the Society a year of achievement that will long be remembered.



WILLIAM MERRILL MILLS, M.D.  
*President-Elect*

# *Scientific Motion Pictures*

(Tentative)

COMPOUND DEPRESSED FRACTURE OF SKULL  
 CORRECTION OF NASAL DEFORMITIES  
 COMPLETE NECK DISSECTION FOR METASTATIC CARCINOMA  
 TREATMENT OF WAR BURNS OF HAND  
 PURPOSEFUL SPLINTING FOLLOWING INJURIES OF THE HAND  
 SUBTOTAL THYROIDECTOMY FOR PRIMARY HYPERTHYROIDISM  
 CANCER OF THE FEMALE BREAST, DIAGNOSIS AND TREATMENT  
 LUMBAR SYMPATHETIC GANGLIONECTOMY—LERICHE APPROACH  
 OBSTRUCTIVE RESECTION WITH COMPLEMENTARY CECOSTOMY  
 RESECTION OF THE COLON AND PRIMARY END-TO-END ANASTOMOSIS  
 WITH COMPLEMENTARY CECOSTOMY  
 VAGINAL HYSTERECTOMY, CLAMP METHOD FOR UTERINE PROLAPSE.  
 PRICE-KENNEDY OPERATION  
 VAGINAL HYSTERECTOMY, SUTURE METHOD FOR UTERINE PROLAPSE  
 JOINT DEBRIDEMENT. EXPERIMENTAL AND CLINICAL FINDINGS IN THE  
 SURGICAL TREATMENT OF ARTHRITIS  
 SURGICAL TREATMENT OF VARICOSE VEINS AND ULCERS. LIGATION  
 WITH SEGMENTED RETROGRADE SCLEROSIS OF THE SAPHENOUS VEIN

SPONSORED BY MEDICAL ANESTHETISTS OF WICHITA

DYNAMICS OF RESPIRATION  
 SIGNS OF INHALATION ANESTHESIA  
 ROLE OF CARBON-DIOXIDE IN CONVULSION DURING ANESTHESIA  
 INHALATION THERAPY IN CLINICAL DISEASE  
 PHYSIOLOGY OF ANOXIA  
 EFFECT OF ACUTE OXYGEN WANT ON BLOOD PRESSURE

# *Technical Exhibits*

*Booth 1*

ELI LILLY AND COMPANY  
 Indianapolis, Indiana

The Lilly exhibit will feature an interesting demonstration in miniature on penicillin culture. Many Lilly products will be on display, and attending Lilly medical service representatives will be present to assist visiting physicians in every possible way.

\* \* \*

*Booth 2*

SHARP AND DOHME, INC.  
 Philadelphia, Pennsylvania

Sharp and Dohme will feature tyrothricin concentrate for human use, "Lyovac," normal human plasma, "Sulfathalidine," "Sulfasuxidine" and "Caligesic" ointment, a greaseless anesthetic and analgesic ointment which possesses definite antipruritic action. A cordial welcome awaits all visitors.

\* \* \*

*Booth 3*

MUNNS MEDICAL SUPPLY COMPANY, INC.  
 Topeka, Kansas

This exhibit will feature a variety of medical and surgical supplies. Mr. Clarence Munns, Dr. C. F. Bouschor and Mr. Tom Walker will be in attendance and extend a cordial welcome to all visitors.

*Booth 4*

PET MILK SALES CORPORATION  
 St. Louis, Missouri

This will be a complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

\* \* \*

*Booth 5*

HOLLAND-RANTOS COMPANY, INC.  
 New York, New York

You are cordially invited to visit the Holland-Rantos booth where the nationally known and universally used Koromex contraceptive specialties will be on display. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, will be the new Nylmerate Jelly introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin. Representatives of the company will answer all questions and distribute samples and copies of the Dickinson-Freret chart.

*Booth 6*  
**SCHERING CORPORATION**  
 Bloomfield, New Jersey

Schering professional service representatives, with new descriptive literature, will present and discuss the latest developments in endocrinology, roentgenological visualization, sulfonamide chemotherapy and pharmaceutical products.

\* \* \*

*Booth 7*  
**W. E. ISLE COMPANY**  
 Kansas City, Missouri

We will have on display our complete line of artificial limbs, orthopedic appliances, surgical supports, maternity belts, elastic hosiery and trusses. Our representatives will discuss with you these appliances, many of which you frequently prescribe. They will welcome your examination of Isle products.

\* \* \*

*Booth 8*  
**MEAD JOHNSON AND COMPANY**  
 Evansville, Indiana

"Servamus Fidem" means "We are Keeping the Faith." Almost every physician thinks of Mead Johnson and Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials, including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth 8 will be time well spent.

\* \* \*

*Booth 9*  
**WILLIAMS S. MERRELL COMPANY**  
 Cincinnati, Ohio

The Merrell exhibit will feature the new Hexestrofen tablets, combining the true estrogen Hexestrol with phenobarbital, for more complete treatment of the menopausal syndrome. Other distinctive Merrell specialties shown will include Infa-Concemin, the vitamin B complex-iron supplement for infants and children, and Sulfa-Ceeprym cream, a more effective treatment for impetigo and other dermatological affections.

\* \* \*

*Booth 10*  
**PARKE, DAVIS AND COMPANY**  
 Detroit, Michigan

Representatives of Parke, Davis and Company, well informed concerning progress in pharmaceutical research, and desirous of presenting new advancements to you, will be in attendance at our exhibit to discuss the nature and employment of new and present products. Displayed will be Theelin, Mapharsen and Adrenalin preparations. The latest type of biologicals will be on display. Penicillin and other therapeutic agents of antibiotic, biological and chemotherapeutic interest will be shown. We sincerely invite your visit.

\* \* \*

*Booth 11*  
**GERBER PRODUCTS COMPANY**  
 Fremont, Michigan

You are invited to visit Gerber's Baby Foods booth. Booklets on infant feeding and special diets are available. Baby cereals, strained and chopped foods will be on display.

*Booth 12*  
**PITMAN-MOORE COMPANY**  
 Indianapolis, Indiana

The Pitman-Moore display will feature a number of pharmaceutical and biological products of interest to the medical profession, but the primary purpose at the exhibit will be to furnish an opportunity for the company's representatives in this area to meet their friends in the profession and to discuss some of the recent medical advances.

\* \* \*

*Booth 13*  
**SIEBRANDT MANUFACTURING COMPANY INC.**  
 Kansas City, Missouri

This exhibit will feature a new type portable fracture table which will serve for reduction and alignment of the various conditions required in fracture treatment. Built of plywood, plastic and aluminum, it is fully transparent for x-ray service. The outstanding feature is a full length cassette tunnel for holding all sizes of x-ray cassettes for examinations without disturbing the patient. The legs of the table are removable. Also displayed will be the Goodwin bone clamp, Clayton transfixion splints and other fracture equipment.

\* \* \*

*Booths 14-15*  
**WESTINGHOUSE ELECTRIC CORPORATION**  
 Kansas City, Missouri

The Westinghouse Electric Corporation X-ray Division representatives will be only too glad to welcome members of the Kansas Medical Society and discuss with them all the latest improvements in x-ray equipment.

\* \* \*

*Booths 16-17*  
**VANPELT AND BROWN, INC.**  
 Richmond, Virginia

You are cordially invited to visit the VanPelt and Brown booth where V and B specialties will be displayed. Among them will be Barbiddonna, Theobarb, Bellaspro, Gluco Ferum, Viazole and Virgitalis.

\* \* \*

*Booth 18*  
**RILEY'S DRUG STORE**  
 Wichita, Kansas

In our exhibit we will feature trusses, surgical belts and doctors' office supplies.

\* \* \*

*Booth 19*  
**GENERAL ELECTRIC X-RAY CORPORATION**  
 Chicago, Illinois

Factual discussions with members of our Kansas sales and service organization during the state meeting will aid you in your future apparatus planning. If you are thinking about new and improved x-ray or electro-medical apparatus, our layout engineers can help you with detailed plans and specifications. Possibly an improvement in radiographic end results is indicated. Or you may wish to know how G. E.'s periodic inspection and adjustment service can help keep your equipment at its maximum operating efficiency. Avail yourself of our wide experience.

\* \* \*

*Booth 20*  
**RIGGS OPTICAL COMPANY**  
 Kansas City, Missouri

This exhibit will feature Bausch and Lomb products.

\* \* \*

*Booth 21*  
**LEDERLE LABORATORIES, INC.**  
 New York, New York

*Booth 23*

M AND R DIETETIC LABORATORIES, INC  
Columbus, Ohio

M and R Dieteric Laboratories will display Similac, a food for infants deprived either partially or entirely of breast milk. Mr. B. C. Palmer will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

\* \* \*

*Booth 24*

ACOUSTICON-HABIGER COMPANY  
Wichita, Kansas

Hearing is restored by Acousticon to the fullest degree possible with a mechanical aid. This eight-point hearing system is based on research to meet U. S. Government Findings and Recommendations. Ears need different lenses for different types of hearing deficiencies. This new Acousticon Unipac has a battery so small it barely covers the end of the thumb, yet generates amazing power. It is light and compact. See it and try it at the Acousticon exhibit.

\* \* \*

*Booth 25*

DAIRY COUNCIL OF WICHITA  
Wichita, Kansas

The Wichita Dairy Council's exhibit will depict the food value of ice cream and the dietary value of homogenized milk. Scientific facts translated into everyday language are the features of the health education materials available for distribution to patients.

\* \* \*

*Booth 26*

C. B. FLEET COMPANY, INC.  
Lynchburg, Virginia

\* \* \*

*Booth 27*

WHITE LABORATORIES, INC.  
Newark, New Jersey

White Laboratories, Inc., will present information regarding White's Sulfathiazole gum, expressly formulated for topical chemotherapy in oropharyngeal infections; White's Otomide, a more effective means of topical chemotherapy in ear infections; and a new specialty, White's Mol-Iron tablets, a new and definite advance in the treatment of iron deficiency anemias. White's vitamin specialties are also featured. You will find a cordial welcome by White's medical service representatives in charge of the exhibit.

\* \* \*

*Booth 28*

H. G. FISCHER AND COMPANY  
Chicago, Illinois

Every visitor is cordially invited to visit our Fischer booth. Ask about the new after-the-war models of apparatus already available or soon to be announced. All Fischer x-ray and electro-surgical-medical equipment is quality built. Our representatives will be glad to answer questions, to furnish illustrated and descriptive literature on all units of the complete Fischer line.

\* \* \*

*Booth 29*

DUMAS-WILSON AND COMPANY  
St. Louis, Missouri

Dumas-Wilson and Company extends physicians a cordial invitation to visit our exhibit displaying primary yeasts in several strains of varying potencies. These strains are offered in tablets, powder, chips and liquid. Displayed will be amino acids for oral use which are now available in concentrated form and with dextrose and malt. These hydrolysates are prepared from primary yeast protein.

*Booth 30*

BURROUGHS WELLCOME AND COMPANY  
New York, New York

Burroughs Wellcome and Company cordially invite physicians to their exhibit of a representative group of fine pharmaceuticals and chemicals. Of particular interest are Globin Insulin, a new advance in diabetic control; Digoxin, a pure, stable, crystalline glycoside of Digitalis lanata, combining constant, uniform potency with rapidity of action; Dexin High Dextrin Carbohydrate, the milk modifier in which the non-fermentable portion predominates, and Lubafax brand surgical lubricant, our latest preparation.

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*Booth 32*

NESTLE'S MILK PRODUCTS, INC.  
New York, New York

The exhibit of Nestle's Milk Products, Inc., will feature their powdered milk product Lactogen and their liquid milk product Dexhydrogen. All physicians interested in infant feeding are invited to visit the exhibit where Miss B. Stokes will be in charge.

\* \* \*

*Booth 33*

PHILIP MORRIS AND COMPANY, INC.  
New York, New York

Philip Morris and Company will demonstrate the method by which it was found that Philip Morris cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

\* \* \*

*Booth 34*

THE ZEMMER COMPANY  
Pittsburgh, Pennsylvania

The Zemmer Company extends to the members of the Kansas Medical Society and their guests a cordial invitation to visit their exhibit where they will display a number of their leading pharmaceutical products.

\* \* \*

*Booth 35*

BROOKS APPLIANCE COMPANY  
Chicago, Illinois

Our display consists of a line of first aid dressings and bandages manufactured by D. C. McLintock Company of Paterson, New Jersey; needles and syringes manufactured by MacGregor Instrument Company and Beckton, Dickinson and Company, and a short line of instruments used in the practice of proctology.

\* \* \*

*Booth 36*

FARNSWORTH LABORATORIES  
Chicago, Illinois

We invite you to talk with our representative on brucellosis or undulant fever and migraine headaches. Literature covering the above treatments may be obtained upon request.

\* \* \*

*Booth 38*

ORTHO PHARMACEUTICAL CORPORATION  
Linden, New Jersey

Ortho Pharmaceutical Corporation will exhibit their well-known council accepted products for the control of conception. Their other gynecological pharmaceutical specialties will be shown, including the new triple sulfa vaginal cream specifically designed for bacterial infections.

\* \* \*

*Booth 39*

GREB X-RAY COMPANY  
Kansas City, Missouri

*Booth 40*

**CIBA PHARMACEUTICAL PRODUCTS, INC.**  
Summit, New Jersey

Ciba invites you to visit its display. Among products exhibited will be Privine, a nasal vasoconstrictor; Metandren Linguels, a potent androgen for absorption from under the tongue or inside the cheek; Nupercaine, a spinal anesthetic; Vioform, for trichomonas, and many other products. Our representative will be glad to give samples and literature on our products and answer any questions you may have.

\* \* \*

*Booth 41*

**AMERICAN OPTICAL COMPANY**  
Southbridge, Massachusetts

\* \* \*

*Booths 42-43*

**A. S. ALOE COMPANY**  
Kansas City, Missouri

A. S. Aloe Company will feature their line of Steeline furniture, late developments in diagnostic and surgical instruments, physiotherapy and laboratory equipment. Mr. Max Coe, recently discharged from the service, and Mr. Martin Hersh will be on hand again to greet new and old friends. Ask about their surplus specials.

\* \* \*

*Booth 45*

**FREDERICK STEARNS AND COMPANY**  
Detroit, Michigan

You are cordially invited to visit our exhibit. Neosynephrine Hydrochloride products for intranasal, parenteral and ophthalmic use will be featured. Appella apple powder, remarkably efficient therapy for diarrhea; gastric mucin, "nature's antacid," and various vitamin products will also be shown. Members of our professional staff will be in attendance to discuss these products with you.

\* \* \*

*Booth 46*

**WESTERN TYPEWRITER COMPANY**  
Wichita, Kansas

\* \* \*

*Booth 48*

**MASEMORE ADJUSTMENT COMPANY**  
Wichita, Kansas

\* \* \*

*Booth 55*

**COMMERCIAL CASUALTY COMPANY**  
Newark, New Jersey

\* \* \*

*Booth 56*

**NATIONAL LIVE STOCK AND MEAT BOARD**  
Chicago, Illinois

The National Live Stock and Meat cordially invites you to visit its exhibit. Nutrition literature including a reader for elementary school children will be displayed.

\* \* \*

*Booth 60*

**KANSAS PHYSICIANS' SERVICE**  
Topeka, Kansas

*Booth 61*

**KANSAS HOSPITAL SERVICE**  
Topeka, Kansas

\* \* \*

*Booths 65-66*

**GOETZE NIEMER COMPANY**  
St. Joseph, Missouri

Goetze Niemer will exhibit some typical samples of the complete line of nationally advertised brands of surgical equipment and supplies for physicians that they regularly carry in all of their four conveniently located warehouses.

\* \* \*

*Booth 68*

**J. B. LIPPINCOTT COMPANY**  
Philadelphia, Pennsylvania

J. B. Lippincott Company presents a complete list of Lippincott selected professional books. New books include Derbes and Englehardt on Hay Fever; Guthrie's History of Medicine; Bailey's Diagnosis and Management of the Thoracic Patient; Campbell's Everyday Psychiatry; Scherf and Boyd's Electrocardiography; Bancroft and Murray's Surgical Treatment of the Motor-skeletal System; Bancroft and Pilcher's Surgical Treatment of the Nervous System; Groff and Houtz' Manual of Diagnosis and Management of Peripheral Nerve Injuries; Foot's Pathology in Surgery; Geschickter's Disease of the Breast; Burkett's Oral Medicine; Berens and Zuckerman's Diagnostic Examination of the Eye, and Conduction Anesthesia, edited by Southworth and Hingson. Advance information on other new books and new editions in preparation.

\* \* \*

*Booth 69*

**CEROPHYL LABORATORIES, INC.**  
Kansas City, Missouri

Presenting Cerophyl, the natural food supplement, rich nourishment from dehydrated cereal grasses, for supplemental diets and ordinary diets.

\* \* \*

*Booth 72*

**UNITED MEDICAL EQUIPMENT COMPANY**  
Kansas City, Missouri

We will exhibit our new direct-recording electrocardiograph, the Cardiotron, manufactured by the Electro-physical Laboratories of New York. We will take cardiographs on the doctors at our booth, and the doctors can watch the graphs actually being taken and read them immediately. After 12 years of research the Cardiotron is now offered to physicians and hospitals. It is portable, simple to operate, and requires no technician.

\* \* \*

*Booth 73*

**MEDICAL PROTECTIVE COMPANY**  
Fort Wayne, Indiana

The Medical Protective Company is represented at booth 73 where you are invited to call. Medical Protective Service is an institution of the medical profession whose legal liability problems we have concentrated upon for 47 years.

\* \* \*

*Booths 74-75*

**MID-WEST SURGICAL SUPPLY COMPANY, INC.**  
Wichita, Kansas

Mid-west Surgical Supply Company will exhibit the Model No. 1075 operating table. Beck Lee Electrocardiograph. Cystoscopic equipment. Ritter E.N.T. unit, including x-ray and other items currently available. Cy Jennings, Fay Martin, Harold Goodwin and George Smith will be in attendance.

*Booth 76*QUINTON-DUFFENS OPTICAL COMPANY  
Topeka, Kansas

Quinton-Duffens Optical Company, in booth 76, will feature Ophthalmic lenses.

*Booth 79*COCA-COLA COMPANY  
Atlanta, Georgia

The Coca-Cola Company will distribute complimentary bottles of Coca-Cola to all guests who stop by the booth.

## *General Information*

### PLACE OF MEETING

The Wichita Forum, located at the intersection of Williams and Water streets, will again be headquarters for the annual session. All scientific assemblies, the exhibits and registration desks will be at this location.

### REGISTRATION

Registration headquarters will be at the Wichita Forum. This office will be open from 8:30 a.m. to 6:00 p.m. each day. Tickets for all special events may be obtained at the registration desk.

The Constitution and By-laws of the Society provides that every physician must register before he shall be entitled to attend any of the events of the meeting. Identification is by the presentation of a 1946 membership card. In lieu of a membership card, identification may be made only with certification by the secretary of the County Medical Society or by an officer of the Kansas Medical Society.

### TELEPHONE SERVICE

Local and long distance telephones will be available near the registration desk. The number of the long distance line is 2-9061. Place this number at the disposal of your office if calls are expected.

### PAGE SERVICE

Boy Scouts will serve as pages and to handle telephone calls. Special screens and lanterns will be placed in each section meeting room and names of physicians will be thrown upon the screens, thus eliminating confusion during the meetings. Members expecting calls are expected to notify the registration desk.

## HOUSE OF DELEGATES

The Constitution and By-laws provides that the House of Delegates shall meet on the first and on the last day of each annual session. The first meeting will be held on Monday, April 22, in the Empire room, Allis hotel, at 8:30 p.m. The second meeting will be held at 4:00 p.m. on Thursday, April 25, again at the Allis hotel in the Aviation room.

The Constitution and By-laws provides that each county medical society shall be entitled to send to the House of Delegates each year, one duly qualified delegate for every 20 members, and one duly qualified delegate for each major fraction thereof; provided that each component society has made its annual report and paid its assessments as provided in the Constitution and By-laws. In the event that a delegate finds it impossible to attend, the By-laws provide that he shall appoint an alternate to attend and serve in his place and that such alternate shall qualify himself to the committee on credentials.

Many matters of extreme importance are scheduled upon the agenda for this year's House of Delegates meetings, and every county medical society is urged to have its delegates or alternates present at both of the meetings. All members of the Society are invited to attend the meetings of the House of Delegates.

## GOLF TOURNAMENT

The annual golf tournament of the Kansas Medical Society will be held at the West-lakes golf course, 5828 Maple on Monday, April 22. This is west of the city on highway 54. Practice rounds will begin at 10:00 a.m. and competitive play is scheduled to begin at 1:00 p.m.

## SKEET SHOOT

The first skeet tournament since the war will be held at the Wichita gun club beginning with practice shooting at 10:00 o'clock and competitive shooting at 1:30 p.m. on Monday, April 22. The Wichita gun club is located on West Maple, approximately five miles west of Wichita on highway 54.

## HOTEL RESERVATIONS

If you have not been successful in making reservations for the annual session, write to Mr. H. Martin Baker, Executive Secretary, Sedgwick County Medical Society, 1003 Schweiter Building, Wichita, 2, Kansas.

The Sedgwick County Medical Society, host to the annual session, has made local arrangements to assure reservations for all who plan to attend.

# Woman's Auxiliary Annual Meeting

TUESDAY, APRIL 23

9:00 A. M. REGISTRATION

*Rose Room, Forum* (North Entrance)—Open 9:00 A.M. to 4:00 P.M.

10:00 A. M. PRECONVENTION BOARD MEETING

*Ingalls Room, Allis Hotel*

1:00 P. M. LUNCHEON HONORING MEMBERS AT LARGE

*Wichita Country Club, 840 North Yale Avenue*

HAT AND HAIR STYLE SHOW FOLLOWING LUNCHEON

WEDNESDAY, APRIL 24

9:00 A. M. REGISTRATION

*Rose Room, Forum*—Open 9:00 A.M. to Noon

9:30 A. M. GENERAL SESSION

*Aviation Room, Allis Hotel*

11:45 A.M. LUNCHEON HONORING OFFICERS, SPECIAL GUESTS

*Spanish Ballroom, Lassen Hotel*

2:30 P.M. PUBLIC RELATIONS TEA

*Ballroom, Allis Hotel*

SOCIALIZED MEDICINE

Mrs. Luther H. Kice, Long Island, New York

7:00 P. M. ANNUAL BANQUET AND DANCE

THURSDAY, APRIL 25

10:00 A. M. COFFEE

Institute of Logopedics, Wichita University, 1751 Fairmount Avenue  
(Transportation May Be Arranged at Registration Desk)

NOON LUNCHEON AND POSTCONVENTION BOARD MEETING

*Lassen Hotel*

# *Retiring President and President-Elect*



MRS. HUGH A. HOPE  
*Retiring President*

with her capable leadership and our continued co-operation the growth and accomplishments of the organization will be even more outstanding in the future.

We are anticipating the pleasure of seeing all of you at Wichita in April. We were not permitted to greet you last year because of restricted travel, but this year we will have an old-time full convention, so come one, come all.

Mrs. Hugh A. Hope.

"Forward—Auxiliary" is our slogan for the coming year. Yes, forward in a spirit of FRIENDLESS and CO-OPERATION.

We all know the purposes for which we are organized, but during the past few years the defense program, of necessity, has crowded our busy schedule to such an extent that the Auxiliary has, to some of our members, become secondary.

With our doctors, for the most part, back "home" again, let us extend a hand of welcome to their wives, and by friendliness stimulate attendance at our meetings, making our Auxiliary not secondary but first. By co-operation, having as our objective the fulfillment of any assignments handed to us by the Medical Society. For this latter service we are rewarded by the personal satisfaction of assisting the noblest profession on this earth, the practice of medicine.

Remember the key words: FRIENDLINESS and CO-OPERATION, and then, Forward—Auxiliary.

Mrs. Henry Lewis Regier.



MRS. HENRY LEWIS REGIER  
*President-Elect*

## PRESIDENT'S PAGE

*To the Members of The Kansas Medical Society:*

The Kansas Medical Society's agreement with the Veterans' Administration was put into operation today, April 1, 1946. There are approximately 800 doctors who have been certified as fee-designated Veterans' Administration physicians, both as general examiners and as specialists. Because of the magnitude of the undertaking, we will naturally have a great amount of confusion for the first few weeks until the men familiarize themselves with the instructions. These will be sent to you as soon as they are off the press. Please read them carefully so that you will understand who is eligible for care and how to secure authorization for that care. This will help us materially.

Once again I wish to call your attention to Kansas Physicians' Service. You should understand that the fee schedule as written applies only to the lower income group. To the groups above this income bracket, the policy becomes an indemnity policy and does not have anything to do with your fee. These are details which cause misunderstandings and criticism; this we want to avoid.

The postgraduate fund should, by all means, be continued. We have already paid the allowance of \$200 to a number of the men who have returned from the service and who are now taking, or have taken, their postgraduate work.

Tomorrow, April 2, is the opening day of the hearings on the Wagner-Murray-Dingell bill. I wish every member of the Kansas Medical Society would secure a copy of the testimony that will be given by Watson B. Miller of the Federal Security Administration, by Surgeon General Parran of the United States Public Health Service, and by A. J. Altmeier, chairman of the Social Security Board. These men are scheduled to testify, and we as individuals should follow very carefully the statements of these public officials. Do not forget that these bills are not defeated and every member of our Society should wire his senator and his representative his opposition to these bills. Five members will testify for the American Medical Society. No member of any state society will be allowed to testify, owing to the great number of national organizations that have been invited. We will have to be content with submitting to Senator Murray written statements which we will have introduced into the printed record at the hearings.

There is no greater weapon with which to fight such bills as the Wagner-Murray-Dingell bill or the Pepper bill than to offer good medical service to the laity at fees within their means. Arrangements have been made to care for those in the lower income brackets by Kansas Physicians' Service. Furthermore, arrangements have been made to care for veterans by Veterans' Administration physicians. The foundations for these ventures have been laid by the past and present officers of the Kansas Medical Society. Now it is your responsibility. Whether or not these ventures will be successful depends entirely upon the quality of service you, as individuals, will render. Let us all work together for better medical care and cut the props from under socialized medicine.

We hope that you will be able to attend the state meeting of the Kansas Medical Society in Wichita the last of this month. The Sedgwick County Medical Society has provided an excellent scientific program, as well as plenty of recreation. Lock up your office and spend a few days with us.



President

## EDITORIALS

### The Other Side of the Fence

Regimentation is a peculiar situation. It is very fine for the other fellow, as long as it does not tread upon our toes. But when it treads upon our toes it becomes definitely undesirable.

It is time that we, as physicians, realize that there is going to be some degree of regimentation in medicine. How great the degree will depend upon the cooperation of every ethical and clear thinking physician in the United States of America.

In an editorial in the March issue of the Journal of the Kansas Medical Society, reference was made to the type of regimentation that labor demands of medicine. The labor leaders speak glibly of leaving the scientific problems of medicine to the doctors, but they request the right to sit in on discussions and dictate the terms that determine the economic plane upon which doctors must subsist. They speak of compulsory insurance and federal control in the same breath. But is this the answer?

At present labor and its varying factions do not seem to want to cooperate with their employers or even with other locals of their own union. Will they be any more cooperative with medicine? It will take a long time for the unionized automobile workers of General Motors to compensate at 18½ cents per hour for the 125 days of work that they failed to complete by virtue of, if there is any virtue in, strike. Are the unions going to pay for the workers' compulsory medical insurance out of the dues to their organization when the workers are out on a strike? They request that the commodity price not be raised. How can this be brought about except by producing an inferior product, thereby indirectly increasing the commodity price.

If we consider the practice of medicine a commodity, which in reality it is, do we want it under federal control? No, that is not the answer. Does labor want it under control? We do not think so. Labor wants the commodity of medical care delivered to its door in an efficient and economical manner. If labor wants compulsory health insurance, they can get it by requiring their members to carry insurance in voluntary, non-profit pre-payment plans. That would insure the commodity of medical care at the lowest possible rate. This would preclude the paying of thousands upon thousands of clerks, stenographers, bookkeepers, directors and, last of all, investigators which would be necessary to put medical care at their door under federal control.

Certain of our members in the minority favor governmental control of as many branches of medicine

as possible. However, they are not interested in the practice of medicine per se. They are interested in the administration of medical affairs on a 40-hour week basis with well trained physicians as office boys. That doesn't take care of the sick patient at midnight or on Saturdays and Sundays.

During the past four years, many of us have had the privilege of practicing medicine in a regimented way. The word privilege is used because we believe that it will be one of the main factors in producing an organized front for medicine in the next few years. We have seen the wanton waste of scientifically trained manpower, instruments and supplies. We have seen office after office filled with clerks just to keep records. We have seen the entire routine of a portion of the medical staff of a hospital upset for a day to track down an unjustified complaint.

Labor lauds the scientific advances of medicine in one breath and lambasts it in the next by quoting comparative international statistics. One can prove anything by statistics, particularly if the yardstick for measuring these statistics is a different length in every country.

On the other side of the fence we, as doctors, think that the doctors have done pretty well by the American people. We have organized free clinics and medical centers for the care of those who have been unable to pay. Funds for the support of these institutions have been gleaned from those who are able to pay. The medical philanthropists in the United States have put our teaching centers on a higher plane than any other country in the world. Our doctors no longer have to go to Vienna or Hamburg for medical education. They can do better at home under a system which has grown up under free enterprise and in the true American way.

So, there are two sides of the fence, our side and the other side. On our side we must produce and offer to the public, labor included, the commodity of medical care at a fair and just rate. We think that the public can purchase this commodity cheaper if they deal directly with us than they can if they purchase the same commodity through a middleman, who in turn must hire us to produce the commodity.

### Proposed Child Health Survey

On Sunday, March 31, Dr. Earl Padfield called a meeting in Topeka of some of the pediatricians of the state and representatives of the State Board of Health to discuss a proposed Child Health Survey. He is expecting to present this project to the House of Delegates for approval.

The Child Health Survey is a national project, sponsored by and partly financed by the American Academy of Pediatrics. Its purpose is to determine

(Continued on Page 180)

# Kansas Medical Assistants' Society

Annual Meeting, April 21 and 22, 1946

Allis Hotel, Wichita, Kansas

Registration Fee—\$3.00

## SUNDAY, APRIL 21

Registration from 9:00 A. M. to 2:00 P. M.

2:00 to 5:00 P. M. First Session—Aviation Room

Address of Welcome—John L. Kleinheksel, M.D., President of Sedgwick County Medical Society, Wichita, Kansas

Response—William Merrill Mills, M.D., President-elect of Kansas Medical Society, Topeka, Kansas

Safeguarding Your Doctor's Interest—Mr. J. E. McCurdy, General Agent, Medical Protective Company, Topeka, Kansas

Kansas Physicians' Service—Barrett A. Nelson, M.D., President of Kansas Physicians' Service, Manhattan, Kansas

Music—Wesley Nurses' Chorus under direction of Miss Margaret Motter, Wichita, Kansas

Remarks—Medical Advisors to Kansas Medical Assistants' Society

5:00 to 7:00 P. M. Open House—Ingalls Room

Hospitality Hour with Members of the Sedgwick County Medical Assistants' Society as Hostesses

## MONDAY, APRIL 22

Registration from 9:00 to 10:00 A. M.

10:00 A. M. to 12:00 Aviation Room

Experiences of a Japanese Prisoner and the Work of the American Red Cross—Mr. William Warren, American Red Cross, Wichita, Kansas

Management of the Female Patient—Robert H. Maxwell, M.D., Wichita, Kansas

The Future Medical Assistant—Mr. Oliver E. Ebel, Executive Secretary, Kansas Medical Society, Topeka, Kansas

12:00 Ball Room

Luncheon, Business Meeting, Election of Officers, Installation of Officers

# The First Year

THE SUCCESSFUL NUTRITIONAL history of S-M-A babies is due to the remarkable similarity of S-M-A to mother's milk. It is essentially the same as human milk in percentage of protein, fat, carbohydrate and ash, in chemical constants of the fat and in physical properties.

S-M-A\* IS RECOMMENDED for normal, full term infants in the early weeks of life when a supplementary food is required for the breast-fed infant. It may be given to infants of any age whenever the mother's milk is unavailable, of poor quality or insufficient quantity.



S-M-A is derived from the milk of tuberculin-tested cows. Part of the butter fat of this milk is replaced with animal and vegetable fats, including biologically assayed cod liver oil. Milk sugar, vitamin A and D concentrate, carotene, thiamine hydrochloride, potassium chloride and iron are added.

\*REG. U. S. PAT. OFF.

*Supplied: 1 lb. tins with measuring cup.*



**PROPOSED CHILD HEALTH SURVEY**

(Continued from Page 175)

the type of medical care that the children of this country are obtaining. Thereby we shall be able to substantiate our own statements on child health and care by factual statistics. By the same token, we as doctors can refute quotations of statistics, the source of which is questionable.

Dr. John P. Hubbard was selected by the American Academy of Pediatrics to direct this survey. Dr. Ward Chadwick of Denver was obtained as the representative in the central district. Dr. Chadwick was present at the meeting Sunday and gave the assembled doctors considerable information about the aims of the survey and the methods of obtaining the required information.

One state survey has been made to date and several states are now making or planning to make a survey.

It would seem that a survey of this type is a worthwhile project and that it might be extended to other branches of medical practice. It most certainly deserves the careful consideration of the House of Delegates.

**ANNOUNCEMENTS**

General oral and pathology examinations (Part II) for all candidates will be conducted by the American Board of Obstetrics and Gynecology at Chicago from Monday, May 6, through Saturday, May 11. Headquarters will be at the Palmer House.

Applications are now being received for the 1947 examinations. Further information and application blanks can be secured from Dr. Paul Titus, secretary, 1015 Highland building, Pittsburgh 6, Pennsylvania.

\* \* \*

The next oral and written examination for fellowship in the American College of Chest Physicians will be held at San Francisco June 29, 1946. Applicants should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn, Chicago 10, Illinois.

\* \* \*

A one-week didactic and clinical refresher course in otolaryngology has been arranged for specialists in the field, May 13 to 18, inclusive, by the Illinois College of Medicine. Applicants should send information on school of graduation, training and experience, along with check for tuition (\$50) to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago.

A special course, open to 12 physicians, will be offered in Broncho-Esophagology June 3 to 15, inclusive. Tuition is \$100.

# *THE JOURNAL* *of the* **KANSAS MEDICAL SOCIETY**

*Owned and Published by The Kansas Medical Society*

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Volume XLVII

MAY, 1946

Number 5

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## TRENDS IN THE CARE OF THE PSYCHIATRIC CASE\*

Jesse F. Casey, Lt. Colonel, MC, Veterans'  
Administration \*\*

Topeka, Kansas

In a discussion such as this, it is only possible to enumerate—and then elaborate, briefly—some of the trends that have been evolved, and are now developing, in the care of the psychiatric patient. The vast experience gleaned by the handling of casualties in all branches of the armed services has played an important role in the determination of these trends.

One such trend is the development of a spirit of greater optimism in relation to these cases. We are definitely getting away from the prevalent attitude that the psychiatric case is a hopeless one. No longer can we be complacent about them, assuming that the best we can provide is mere custodial care, a place to stay, food, and the prevention of injury to themselves or others. These cases must be helped, and they can be helped. Those of us dealing with them have known this for some time; but the encouraging thing about the present trend is that the optimistic spirit has spread to other fields of medicine, as well as to the attitude of the public in general. The optimistic trend on the part of psychiatrists has not developed on a temperamental basis, but from the observation of clinical results, with new treatment methods and treatment attitudes.

Early in the war, the Army adopted the policy of merely getting rid of psychiatric cases by separating them from service. As the war continued and the manpower situation became more critical, energetic therapeutic measures were instituted, with results that amazed nearly everyone. Excluding the frankly psychotic, approximately 90 per cent of these patients were able to remain overseas and to perform useful service.

Another trend in psychiatry is toward the earlier recognition and treatment of the psychiatric cases, often before they are labelled. As in any branch of

medicine, the best results can be achieved if therapy is begun before the process develops too far. Personal experience in the Army brought this home to me, many times. I have seen numbers of psychiatric patients who were hospitalized and transferred, in turn, to other general and station hospitals for long periods, without the benefit of adequate treatment. Invariably, these cases were much more difficult therapeutic problems, with poorer prognosis for return to useful military duty than would have been the case if the psychiatric tendencies had been recognized in early stages and treatment given accordingly. This same thing is equally true in civil life. We are all familiar with the deteriorated psychiatric case, for whom little hope can be offered, even with the best treatment now at our command. We firmly believe that in many cases, however, this stage of deterioration can be prevented, as certainly as surgical complications can be prevented with proper surgical care.

A very important trend is one directed to the provisions of more adequate treatment. Early treatment that is not adequate will not suffice. One aspect of making therapy adequate is for the therapist to understand, as far as possible, the basis for the disability the patient has. We certainly don't pretend to understand all there is about mental illness, but the trend, today, is to find out all we possibly can about it. To do this we now utilize to the fullest extent the services of a number of allied groups including psychologists, psychiatric social workers, psychiatrically-trained nurses, vocational counsellors, and many others. One cannot go into detail here as to just how these various groups function, but with the aid they can give, a much more comprehensive understanding of the patient and his illness is possible.

To provide more adequate treatment, a definite increase in personnel engaged in psychiatric work is absolutely essential. Many more people are re-

\*Published with permission of Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the author.

\*\*Clinical Director, Winter General Hospital, Topeka, Kansas.

quired than has previously been considered necessary, when patients were regarded chiefly as "custodial problems." Minimum standards have been established for the number of patients one nurse can adequately care for; the number of patients one doctor can adequately treat; and, for the number of patients an attendant can properly supervise. These minimum standards vary with the type of case in question, acutely disturbed patients requiring, of course, more personnel, care and closer supervision than those better adjusted. But with all types, the trend is definitely toward more personnel. This personnel must be adequately trained. Progressive hospitals and treatment centers provide organized courses of instruction, both before and after the employees actually begin the work, with the patients continuing it as they work. Such a program must be continuous to be effective.

Providing adequate treatment now calls for a greater variety of types of therapy. Aside from the definite treatment given directly by the physician, many other types have proven to be of great help. These include: occupational therapy; recreational therapy; bibliotherapy; music therapy; the arts courses; and many others. These must be individually prescribed for each patient, the therapist choosing the particular type best suited for each patient.

The discussion thus far would indicate that everything is directed to the individual treatment of the patient. The increased personnel does allow more time for the individual, and, certainly, therapy administered to each patient, separately, continues to be an important part of our armamentarium. Recent experience has shown, however, that group therapy is a valuable method of attack. For years, it was felt that the very nature of mental illness was such that it could only be approached individually. The experience of those treating these cases in the military service does not bear this out. The large number of cases involved, and the pressing need for rapid treatment, necessitated the devising of techniques in which large numbers could be treated simultaneously. The result was surprisingly encouraging. Of course, the problem in military life is different from the one we now have as civilians; but the same forces employed in bringing about improvement can be utilized in both. Group therapy, meaning here, primarily, "group psychotherapy," has definitely arrived. By its use, forces developed from a group spirit, and a group attitude, are available that cannot be had in any other way.

Another important trend in the care of the psychiatric case provides for their treatment outside the hospital. Many cases needing help do not have to be hospitalized. The Out-patient Psychiatric Clinic fills this need. This falls in line with the trend toward early treatment, as many cases can be treated

who never stop work, and, who, in many instances would otherwise gradually grow worse, until hospitalization becomes necessary. The out-patient treatment also serves as a means of "follow-up" of previously hospitalized cases, frequently preventing the need for re-hospitalization.

A trend that began before the war, and one that has grown continuously, is the closer affiliation of psychiatry with surgery and medicine. Here, again, military experience has shown that a much larger percentage of patients than was previously supposed (hospitalized initially for general surgical and medical conditions) were found to have concurrent psychiatric ailments. In my own experience, this was vividly illustrated immediately following D-Day, in the Army hospitals in the United Kingdom. Many cases hospitalized for wounds, particularly minor wounds, were actually returned to reinforcement depots following successful treatment for the wounds, and were on their way back to combat duty when screening at the reinforcement depot revealed them to be major psychiatric casualties, totally unable to return to any type of duty at that time. This came about as a result of the complete focusing of attention on the surgical condition, itself. Of course the pressure for hospital beds and the acute need for manpower at the fighting front at that time were contributing factors. This condition became so marked, however, that in one area, the Surgical Consultant visited the various hospitals under his jurisdiction for the purpose of drawing particular attention of the surgical staffs to this point. This instance illustrates the necessity for closer liaison between surgery and psychiatry. The Winter General Hospital in Topeka, Kansas, a former Army hospital (now under the control of the Veterans' Administration), planned primarily for the adequate treatment of neuropsychiatric cases and at the same time planned to provide a training center for psychiatrists in the Veterans' Administration, is to be a general hospital caring for surgical and medical cases as well as psychiatric and neurological cases. It is definitely felt that in order to provide well-rounded training in psychiatry, training on surgical and medical wards directed toward the psychiatric aspect is absolutely essential. The medical and surgical services at Winter General Hospital will have, in addition to the usual internists and surgeons, psychiatrists assigned to work exclusively in those services.

To summarize: I have enumerated, and briefly described, several trends now prevalent in the care of the psychiatric cases: the spirit of optimism; earlier and more adequate treatment; greater variety in the types of therapy; increased number of personnel; out-patient treatment; group therapy; and, finally, the trend toward closer affiliation with medicine and surgery.

## THE ROLE OF SECONDARY CLOSURES IN THE MANAGEMENT OF WAR WOUNDS

Joseph J. Mira, M.D.

St. Louis, Missouri

The management of war wounds has been very aptly divided into three phases—initial, reparative and reconstructive. The first two phases are carried out overseas, whereas the third is accomplished in the zone of interior. The initial wound surgery is performed in the forward areas, mainly in evacuation and field hospitals, and is directed toward the preservation of life, the prevention of infection, and the rendering of the patient transportable to the base hospitals usually in the communication zone where the reparative phase of surgery is carried out.

The objective of the reparative phase is to continue the efforts directed against the establishment of infection, and secondly to prevent deformity. In this war, secondary closure of wounds has played a highly important part in the successful accomplishment of this mission, and in fact has been heralded by some as the most significant advance in military surgery during World War II. This paper is intended as a review of the development and successful application of this form of wound management based on the author's direct and indirect experience during 16 months in a general hospital in the European Theater of Operations.

It is an axiom of science that no discovery or development is entirely independent, but rather related to or based upon experiences and discoveries of the past. Secondary closure is not a new surgical principle, but its success on such a wide scale in this war has surprised many surgeons of World War I.

The beginning of the modern treatment of wounds goes back to Desault and Larrey who introduced the principle of early debridement; to Botallo who insisted that dead tissues must be excised; to Ollier who propounded the principle of rest in the healing of wounds; to Lister who greatly enlarged the field of operative treatment by the introduction of aseptic technique. By the time of World War I, the fundamental importance of these principles was well established, and their early adoption led to a marked improvement in results.

The success of this form of treatment led many surgeons with wide and long experience in peacetime surgery to employ primary closure of wounds debrided early—a practice widely upheld in peacetime surgery. This, however, led to numerous serious failures and an immediate reaction set in with the allied surgical centers condemning the use of primary suture. Secondary suture, though not condemned, was not particularly encouraged, and in

the later stages of the war the following criteria were considered necessary to justify the closure of the wound by secondary suture (Fraser et al 1918):

1. Not more than two (2) bacteria per microscopic field must be present.
2. Closure must be effected without undue tension.
3. The edges of the skin must be clean and healthy.

The first of these criteria was not often present, and secondary closure was therefore not widely practiced. At this time the technique of irrigation with Dakin's solution introduced by Carrel was quite popular. In the later stages of the war, and after the war, the principle of treating infections of the extremities and osteomyelitis by provision of drainage and complete immobilization of the limb in plaster of paris was introduced by Winnett Orr. During the Spanish civil war Trueta elaborated on this principle and extended its application to include the treatment of all wounds of the extremities, and this was called the Trueta-Orr treatment.

This very briefly is the background and experience from which the surgeons of World War II had to evolve a successful management of war wounds.

Early in this war (1943) surgeons in the Mediterranean Theater of Operations recognized the exceptionally good condition of wounds upon arrival at base or general hospitals. Undoubtedly, chemotherapy prior to admission (both penicillin and sulfonamids) was an important factor in producing this result. Equal or perhaps even greater importance must be attributed to the high calibre and promptness of the initial surgery, the extensive use of plasma and whole blood in the forward areas, and the speed of evacuation of transportable cases. Under usual circumstances, patients arrive at base hospitals on an average of 72 to 96 hours after being wounded.

It became obvious to these surgeons that in the majority of these wounds, the danger of sepsis had passed. Large open wounds left to heal by secondary intention result in prolonged hospitalization and cicatricial deformity. In order to obviate these undesirable features, secondary suture of wounds was cautiously introduced in this theater. The decision to close wounds was based on an appraisal of the gross appearance of the wound, irrespective of the bacterial flora. Smear and culture were taken on all cases at first, but were later discarded since it was

found that quantitative and qualitative bacteriologic analysis of the flora of the wound provided little helpful information in the prediction of the result. At first closures were effected during the second and third week after injury, but experience proved that in general the optimum time for closure was between the fourth and the tenth day. Parallel series showed that chemotherapy as an adjunct did not materially influence the result.

No serious infective complications were encountered, and a high percentage of the wounds closed by secondary suture healed by primary intention. This led to a very wide and enthusiastic application of this method in other theaters. In fact, some surgeons now claim it is almost justifiable to say that war wounds not closed and completely healed within three or four weeks are being poorly treated. This statement represents enthusiasm which cannot be substantiated in my opinion.

In a short time a definitely established procedure for handling wounds in the general hospitals was developed. Upon admission, each patient was surveyed carefully. New x-rays were taken in most cases since the x-rays which arrived with the patient had been taken prior to the initial surgery, and were frequently soiled and damaged in transit. Blood transfusions were given freely in order to restore the patient's blood status to normal as quickly as possible. Chemotherapy was not employed routinely. Fecal impactions were broken up and enemas given where necessary. Adequate sedation was the rule, and every possible effort was made to allow the patient to secure some rest prior to surgery. Injured extremities were elevated continuously to allow edema to subside. Casts were bivalved on the ward but not removed. Dressings were not changed on the ward except in selected cases where inspection was deemed necessary for some specific reason, and even then a "peek" without disturbing the wound was considered ample in most cases. Patients were then scheduled for surgery on a priority basis according to the ward surgeon's judgment. It was found that an average 200 to 300-patient convoy could easily be handled in the operating room in a period of four to five days, working on an eight-hour day schedule. In this manner, the majority of secondary closures were effected within four to ten days after the patients were wounded.

In the operating room, casts and dressings were removed under anesthesia using standard aseptic technique. In cases requiring skeletal traction, Kirschner wire or Steinmann pins were inserted first since this is essentially a clean procedure. Then the wound was inspected thoroughly. Easily accessible foreign bodies were removed. Most wounds presented a healthy granulating appearance, slight to moderate serous or sero-sanguinous drainage, and

perhaps a thin grayish yellow plastic exudate. One occasionally found shreds of necrotic fascia, tendon, tendon sheath, or muscle which required careful debridement. These wounds were considered suitable for immediate closure providing the closure could be effected without undue tension.

Patients who presented persistent high fever or toxicity were seldom subjected to secondary closure regardless of the appearance of the wound. Wounds which presented a moderate or profuse sero-purulent or frank purulent drainage were not considered suitable for closure, and usually indicated the presence of residual dead tissue. In these cases, a careful and thorough debridement was done and provision was made for adequate dependent drainage. Smear and culture were taken. A fine mesh gauze was applied directly to the wound surfaces and a light compression dry dressing applied. Patient was then returned to the ward for continuous moist dressings of normal saline, azochloramid, penicillin or acetic acid as indicated. A number of these cases would clean up sufficiently by this management to allow closure within 10 to 15 days.

After closure a dry compression dressing was applied. When necessary, manipulation of fractures was accomplished next. Then the affected part was immobilized, utilizing plaster of paris circular cast or traction in balanced suspension as indicated. All fractures of the long bone except where definitely contra-indicated were treated by skeletal traction in compliance with an E.T.O. directive.

Postoperatively, extremities were continuously elevated. Adequate diet and vitamins were administered, and the patient's general comfort was solicited. Dressings were not removed until the 10th or 12th day, at which time sufficient healing had occurred to allow sutures to be removed. Occasionally it was necessary to continue approximation of wound edges by use of butterfly tape. It was the rule to watch the patient carefully, and to inspect the wound only if untoward constitutional signs or symptoms occurred.

It should be emphasized at this point that wounds which have been laid open properly at the initial operation tend to gape widely, and give the impression of extensive skin loss. This appearance is actually due to loss of support of the deep fascia, and skin defects are more apparent than real in the majority of cases. Also, in many cases where skin loss is present, there is an associated loss of soft tissue usually wedge shaped with a resultant diminution of the circumference of the extremity, thus making closure by suture alone possible. Closure of moderate skin defects was frequently made possible by extensive undermining of the local tissue and by utilizing a variety of local plastic procedures, such as rotation flaps, relaxing incisions, etc. At this time

every effort was made to close these wounds completely using split thickness skin graft in conjunction with partial closures where necessary. The facility with which split thickness grafts, even when applied in deep irregular wounds, take successfully at this stage is amazing.

The following factors were considered important in the successful management of this phase of wound healing:

1. The time lag between the initial surgery and the reparative surgery is important. Four to ten days after wounding is considered the optimum time for closure, and has been referred to as the "golden period." Delay beyond this period results in extensive wound fibrosis and fixation of tissues which required extensive undermining, revision of the relatively avascular skin edges, and in general produced less favorable results.

2. The method of suture generally employed was to approximate the skin edges loosely with widely spaced, deep tension type of suture, the vertical mattress type being quite popular. No attempt was made to secure a "hair line" scar which in fact seldom resulted even when attempted. No effort was made to close in layers, and it was found in the majority of the cases that the approximation of the wound edges together with a light compression dressing sufficed to obliterate dead space. The type of suture generally used was silk of adequate tensile strength, but results when other types of suture were used were equally good. Burying of sutures was avoided.

3. Tension was avoided. Basic surgical principles cannot be violated with impunity. It should be emphasized, however, that a certain amount of tension was permissible because of the rapid decrease in tissue edema following closure. Thus, the importance of elevation of the injured extremity pre- and post-operatively is obvious.

4. Experience proved that wounds presenting a serous or sero-sanguinous drainage, and/or a grayish-yellow plastic exudate were suitable for closure. Wounds presenting sero-purulent or frank purulent drainage reflected the presence of residual dead tissue or foreign bodies which precluded closure without preliminary secondary debridement. Qualitative or quantitative analysis of the bacterial flora was not helpful in predicting results.

5. The status of the circulating blood was highly important. Rapid correction of secondary anemia and hypoproteinemia has an extremely beneficial effect on healing.

6. Location of the wound is important. Good mobility and abundant subcutaneous tissue favor successful closure. It was the general experience that closure of wounds of the leg, ankle, and foot frequently resulted in failure, and subsequently di-

rect split and full thickness skin grafting was found necessary to circumvent failure in many of these cases.

7. Chemotherapy has undoubtedly been a factor in widening the scope of this phase of wound management. However, its use was not considered to be a guarantee of success. Parallel series have shown that equally good results were obtained without chemotherapy. The use of both sulfa and penicillin was largely restricted to selected extensive and complicated wounds.

8. Immobilization in plaster of paris cast or by skeletal traction in balanced suspension must be stressed. The principle of rest in the healing of wounds has been well established, and too early motion has resulted in a number of failures.

9. Adequate diet and vitamin intake was encouraged as a part of a deliberate effort to maintain the patient's general resistance at a high level.

The advantages which accrue from successful secondary closure and skin grafting of war wounds cannot be over-emphasized. Prolonged hospitalization has been avoided, and an increased number of wounded soldiers have been returned to duty. Cicatricial deformity has been avoided. Underlying exposed bone is conserved. Prolonged drainage has been obviated. The incidence of secondary hemorrhages has been markedly decreased by closure. In the case of unrecognized partial rupture of larger vessels, the escape of blood into the tissues was slow and resulted in the development of false aneurysms. This allowed careful observation over a period sufficient to allow establishment of collateral circulation, whereas in open wounds, hemorrhage from a partially ruptured vessel was copious and necessitated emergency treatment which frequently resulted in the loss of an extremity.

All experience in this war indicates that the best functional results are obtained when divided nerves are sutured early. Secondary closure makes possible suture of these injured nerves after three weeks, which is considered the optimum time for this procedure. In the European Theater of Operation, wounds complicated by nerve injuries were closed and immediately sent to neuro-surgical centers.

In certain fractures, open reduction and internal fixation are necessary. After secondary closure, these procedures with chemotherapy as an adjunct are feasible and permissible. It must be stressed, however, that open reduction and internal fixation after secondary closure are recommended only when other methods of reduction fail to attain a satisfactory functional result.

Also, it is the general opinion that reconstructive procedures in the zone of interior are markedly facilitated and can be accomplished earlier in these cases. The need for a time-consuming secondary

full thickness skin graft in preparation for a bone graft is frequently avoided, and when necessary is accomplished with greater ease and assurance.

#### SUMMARY

The modern treatment of war wounds evolved from the teaching of Desault, Larrey, Botallo, Ollier, Lister and others, and its scope has been widened by the introduction of chemotherapy, the advances in plasma and whole blood transfusions, and the streamlined organization of military surgical care.

Secondary closure of war wounds is not a new

surgical principle. However, its successful application on such a wide scale was first accomplished and proven during World War II, and plays a highly significant role in the reparative phase of wound management.

Because prolonged hospitalization has been decreased, skeletal and soft part deformity has been prevented, and reconstructive procedures in general have been facilitated by secondary closure, the doctrine of closed plaster treatment is no longer justifiable except in cases of established infection of bone.

## PERIARTERITIS NODOSUM AND WILM'S TUMOR— CASE REPORT

Hughes W. Day, M.D., and H. H. Hesser, M.D.

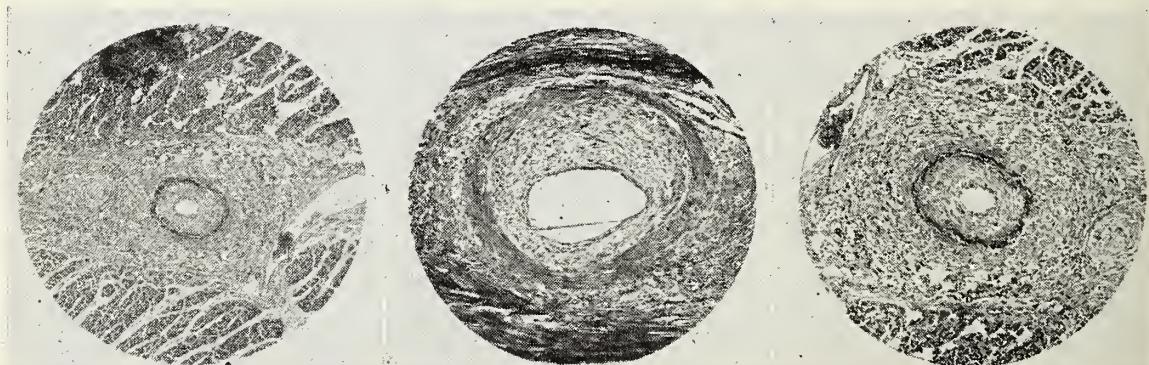
Kansas City, Kansas

The patient is an 11-year-old white male who, at the age of three months, had a Wilm's tumor of the left kidney removed at the University of Kansas Hospital. The boy was given post-radiation therapy. He remained in essentially good health until five weeks prior to his death, at which time he ran a small pen knife into his right thigh. The wound was dressed and the boy was given tetanus anti-toxin prophylactically. Approximately one week later he was awakened in the middle of the night with vomiting and severe upper abdominal pain. The child ran no fever, but continued to complain of severe abdominal pain and vomiting. He was admitted to Bethany Hospital on December 5, 24 hours after the onset of his symptoms.

His admission blood count was 90 per cent hemoglobin; 4,800,000 red cells; with a white count of 17,500. The differential showed 82 per cent neutrophiles, 3 per cent eosinophiles, and 14 per cent lymphocytes and 1 monocyte. His urine revealed a specific gravity of 1.042 with a four plus albumin, occasional pus cells and red cells. He was given

codeine hypodermically, but continued to complain of severe abdominal pain. The following day laboratory reports showed no essential change in the urine or blood count, but his N.P.N. was 99 milligrams per cent. Because of extreme pain over the right side of his abdomen, with rigidity, an exploratory laparotomy was performed on the basis of a possible acute appendicitis, with the kidney findings being explained on an extra renal azotemia. The laparotomy gave negative results except for approximately 300 cubic centimeters of fluid in the abdomen. The child ran no fever for five days, after which time he began to run a temperature of around 102 and 103, associated with a rapid pulse. His severe pain continued. The rigidity of his abdomen decreased. His blood chemistry remained elevated. The N.P.N. was recorded as high as 132 milligrams per cent, his blood sugar 114, chlorides 450, and CO<sub>2</sub> of 35.

Seven days after the exploratory laparotomy, his pain appeared more localized over the right renal area. His white count was 33,000 with 92 per cent



Photomicrograph of Coronary Arteries

neutrophiles. His urine had improved, showing only a one plus albumin with occasional pus cells and numerous red blood cells with granular casts. Because of the high fever and localization of severe pain to the right lumbar area, an exploration of the right kidney was performed to rule out a carbuncle of the kidney. The exploration again proved negative. His temperature, however, gradually fell. His urine improved, the N.P.N. dropping to 34 milligrams per cent. However, he developed a rather high grade anemia with a hemoglobin of 51 per cent, a red blood count of 2,770,000, and a white count of 22,000.

Approximately one week after the exploration of the right kidney, the child's temperature became normal and his pulse rate had gradually fallen to normal. However, he continued to complain of abdominal pain and he also developed pain in his legs, chest, shoulders and arms. He then developed convulsive seizures. The total protein was recorded as 4.5 milligrams per cent. We felt that the convulsions could possibly be explained on a hypoproteinemia, and blood and plasma transfusions were given. Approximately 16 days after his admission to the hospital, signs of peripheral neuritis developed, involving the left arm and hand, followed by a median and ulnar nerve paralysis. His blood pressure on admission to the hospital was normal,

but with the onset of generalized neuritic pains, his pressure readings slowly began to rise, reaching as high as 190/140. Spinal fluid readings were normal throughout. On December 28, approximately three and one-half weeks after the patient's admittance, a differential count revealed an eosinophilia of around nine per cent. At this time we felt that we were dealing with a gradual progressive disease, and it was suggested that the clinical picture could possibly be explained on a vascular basis such as periarteritis nodosa.

On January 1, four weeks after admittance, the child developed signs of a broncho pneumonia, and in spite of penicillin therapy he died 29 days after being admitted to the hospital. The day before his death the N.P.N. was 44 milligrams per cent, his chlorides 480 milligrams per cent, and his total protein 5.5 milligrams per cent. His urine revealed a one plus albumin with occasional pus and red blood cells. The final blood count revealed 64 per cent hemoglobin; 4,160,000 red cells and a white count of 37,650, with 84 per cent neutrophiles, 9 per cent eosinophiles and 7 per cent lymphocytes.

Pathological material obtained at autopsy confirmed the diagnosis of periarteritis nodosum. There was no evidence of any recurrence of the previous malignant tumor.

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The application of chemotherapy methods in the treatment of venereal disease was discussed by Col. Thomas B. Turner, MC, chief of the Communicable Disease Treatment Branch, Medical Consultants Division, at a meeting held by the New York Academy of Medicine on October 12.

The venereal disease rate among soldiers stationed in this country is less than half the rate during World War I, he said, and one-sixth the rate during the Civil War. This progress, he believes, is due to accomplishments of American medicine, both military and civilian, making treatment more effective, more rapid, and less dangerous. Col. Turner is convinced of the necessity for specialists in venereal disease.

Adequate study of streptomycin in treatment of human tuberculosis remains to be done. Certain obstacles lie in the path of further progress along this line.

Many students of tuberculosis believe that results comparable to those noted in acute diseases, such as pneumonia, should not be anticipated in drug therapy of as generally chronic a condition as tuberculosis. In any disease successful treatment with drugs merely permits recovery by natural processes, and the promptness of such recovery depends on the nature of the disease process and the defensive powers of the patient.

Tuberculosis, however, by virtue of its usual chronicity produces destructive changes in tissues. Healing or repair of these tissues is exceedingly slow. Furthermore, in extensive tuberculosis of the lungs the destructive changes offer serious mechanical handicaps to healing. When such mechanical handicaps exist a corrective mechanical type

Pulmonary embolism is an affection of the lungs which is commonly overlooked. Recognition of its frequency and the possibility of its recurrence will enable the physician to avoid failure in its diagnosis. The signs and symptoms especially the triad, hemoptysis, chest pain and fever associated with this disorder are too familiar to a group of chest physicians to warrant discussion. The value of x-ray examination and the presence in many cases of characteristic electrocardiographic findings should be stressed. Even in the absence of these characteristic findings, the presence of an unstable electrocardiogram in seriatum curves taken a few days apart may be helpful.—Louis N. Katz, M.D., in Diseases of the Chest, May-June, 1945.

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of treatment, such as the conventional surgical collapse procedures, is used rather than treatment with a drug. The physician therefore does not hope for any alternative chemical remedy when surgery is indicated. Rest therapy, usually in the planned environment of a sanatorium, will probably remain the fundamental remedy for tuberculosis. No drug now available is likely to supplant rest completely. At this time it would appear foolish to discard the known benefits of rest treatment for the uncertainties of treatment with a new drug.

Patients are frequently eager to receive newly developed drugs even when the hope of benefit is remote. Usually it is impossible to secure such drugs under these circumstances due to present-day legal restrictions designed to prevent unwise distribution of drugs whose safety and efficacy have not been determined.

## PRESIDENT'S PAGE

*To the Members of the Kansas Medical Society:*

I am not a prophet nor a son of a prophet, and have not gazed into the crystal sphere to scan the future between this meeting and the one in 1947. I can foresee one thing clearly—that following a leader like Dr. Callahan will be very difficult. He has done a wonderful job as you all know and deserves the praise and gratitude of all our members. We can clearly see the necessity of a continuance and a revitalization of our present enterprises.

Kansas Physicians' Service is our answer to the complete regimentation of American medicine. It is now four months old, a lusty infant, and growing very rapidly. It will require much careful supervision and possible modification as our experience grows.

Our relations with the Veterans' Administration have been most cordial, culminating in the plan to use our members as a part of their medical staff in certain capacities. A committee of our Society will act in a liaison capacity, arbitrating any differences of opinion and relieving the Veterans' Administration of any policing of our membership.

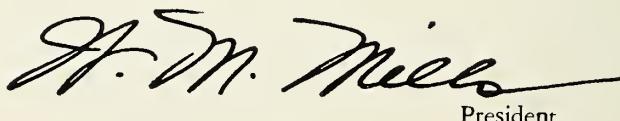
We are faced with the necessity of securing adequate and presentable quarters for our central office. I promise that this will be in a style that will reflect the dignity and importance of our organization, although it may deplete our treasury somewhat. We have no personnel problems in our central office since our staff is adequate and most satisfactory.

We will have one problem which President Callahan escaped—a session of the state legislature. Our motto this time will be "Hold that line"—protect the public from inadequately trained practitioners. With the help of our members returned from service, Kansas doctors can and will furnish adequate medical care for all the people of Kansas.

Service doctors will have a large place in our committee appointments this year and a considerable number of important chairmanships. We feel keenly our debt to them and that we should make up for their years lost from our organization in every possible way.

From the membership I expect and will ask nothing more than the same splendid cooperation you have always given to Dr. Callahan. With your assistance I shall look forward to the coming year with confidence.

Our Society needs and I trust will have a rededication to professional study, professional ethics, unselfish service and the highest citizenship.



H. M. Miles

President

## EDITORIALS

### Eleven Years

Along about the first of July in 1934, one of our members was approached by a representative of the Council of the Kansas Medical Society and asked if he would accept the editorship of the Journal of the Kansas Medical Society. Now this member, thinking more of small mouth bass, the old straw hat, outboard motors and such, flatly refused. He then went merrily on his way to the northlands.

However, the House of Delegates had vested the Council with the power to select an Editorial Board. So, while our member was casting "river runts" and swatting mosquitoes, or maybe cooling off on an Alaskan iceberg, the Council selected him as editor of the Journal. Returning from his vacation, apparently softened by a period of rest and lack of responsibility, he accepted.

On October 1, 1934, the Journal and all its worldly possessions, consisting of a few dollars in the bank, a few contracts for advertising and professional cards, a few unpaid bills, and a contract for printing, were turned over to Merrill Mills, Editor, and four of us satellites, composing the Editorial Board.

Now at that time Merrill Mills did not know 6-point italics from 12-point caps, but, believe you me, he soon found out. He had been given a job and he went about it in true Mills fashion. He called his board together and, with an issue of the Journal in hand, started to pick out the "bugs." "Now look at that cover," said he. "DIARRHEA IN BABIES must go." And so, with a wave of the hand, DIARRHEA IN BABIES disappeared, at least from the front cover of the Journal of the Kansas Medical Society. Thereby, the front cover became an entity, attractive, conservative, and decorated only by a small design which it has borne ever since.

Now, perhaps you have never studied that little design. You will find it in the lower left hand corner of the front cover. Look at it. A wooden stethoscope, the first used in medical practice, surrounded by a modern stethoscope. That design denotes progress. That was Dr. Mills' desire, something to denote progress.

Under the editorship of Dr. Mills, progress has been the password. We have gone from a printed sheet containing a few poorly selected and edited scientific articles and a few advertisements to a most presentable publication, which ranks quite high in publications of its type. We have gone from a publication, subsidized by the Kansas Medical Society at considerable expense each year, to a self-supporting publication with a full time managing editor,

no outstanding bills and money in the bank. As a result of which, the Journal has assumed its rightful place in Kansas medicine.

As the new Editorial Board takes over the reins which have been surrendered by Merrill Mills, we wish him well, and in so doing we pledge ourselves to attempt to carry on in the direction which he has started. We well know that he can pick up any one of the eleven bound volumes of the Journal, which the Society has so aptly presented him, and thumb through it with a feeling of personal satisfaction of a job well done.—*Lucien R. Pyle, M.D.*

### Vale

Laying down the editorial mantle brings many memories, mostly pleasant, of the nearly 12 years during which the Journal of the Kansas Medical Society has been my avocation. It all began after the honor had been declined once, when Henry Tihen traveled to Topeka on the hottest afternoon of the year to urge me to accept. He looked so hot and tired and earnest that it was impossible to refuse him.

We have been fortunate in our office secretaries, Peggy Strawn, Mateel Todd and Pauline Farrell, while Clarence Munns and Oliver Ebel have done yeoman service in countless ways.

The editorial board has functioned very satisfactorily although its meetings have been less frequent during the war years. One original member whose work should be especially mentioned as noteworthy is Robert B. Stewart, who was lured to California a few years ago to our great loss.

Another original board member with continuous service is Lucien R. Pyle, who has been elected editor and takes charge with this issue. We know he will have a lot of headaches, unlimited cooperation from his staff and the satisfaction of doing a constructive piece of work for Kansas medicine. Good luck to you, my friends.—*W. M. Mills, M.D.*

### Lucien R. Pyle, M.D., New Editor

Lucien R. Pyle, M.D., Topeka, was unanimously elected to become the editor of the Journal of the Kansas Medical Society by the Council in a meeting held at Wichita on April 25, 1946. Dr. Pyle assumes this responsibility beginning with the present issue.

Eleven years ago Dr. W. M. Mills of Topeka became the editor of the Journal, and a brief outline of his many accomplishments during his years of service will be found in an editorial entitled "Eleven Years." At the time he became editor a reorganization of Journal policy occurred and an editorial

board was formed. Dr. Pyle became a member of the original board and has served continuously since that time. He has always been active in this position and has repeatedly offered suggestions for improvements in the publication that have been gratefully received. Even during the four years that Dr. Pyle served in the armed forces, he remained an active member of the editorial board. While in service he attained the rank of commander in the United States Naval Reserve. Upon his release from the service in January 1946, Dr. Pyle immediately engaged in Journal activities and since that time has submitted several editorials that have appeared in recent issues.

During the 1946 annual session when Dr. Mills was installed as president of the Kansas Medical Society, he resigned his position as editor. The Council was never in doubt concerning Dr. Mills' successor to this position and immediately voted a unanimous ballot placing the responsibility of this publication in the capable hands of Dr. Pyle.

Also elected at that time were two members of the editorial board. Dr. Orville R. Clark was named to fill a vacancy on the board for a three-year term, and Dr. Dwight Lawson was elected to serve on the board for two years to complete Dr. Mills' unexpired term. Dr. Don C. Wakeman and Dr. Ernest H. Decker, whose terms as members of the board will expire in 1947, continue to serve with the new appointees.

The Journal is the one official publication of the Kansas Medical Society. Even though many purposes could be named, three distinct values stand apart as most important. The Journal offers to the members a medium through which original scientific work may be announced to the profession and recorded. It carries to the membership announcements of events and declarations of policy. It also gives to medical societies in other states the only available means for obtaining information concerning medical affairs in Kansas. The Journal, then, is designed to serve not only the profession in this state but also becomes a medium for exchanging ideas with other societies.

Dr. Pyle and the members of the editorial board are acutely aware of their responsibility and of the opportunity afforded them in this position. The Society has implicit confidence in the judgment of this board and pledges its support toward the end that the Journal will continue to grow and improve as it has grown and improved during the past 11 years.

### 87th Annual Session

The Sedgwick County Medical Society was host to members of the Kansas Medical Society which held the first annual session in several years at

Wichita, April 22-25. The attending physicians extended sincere thanks to the Sedgwick County society for a splendid scientific program and some fine social events provided by the physicians of Wichita. Altogether the meeting was pleasant and profitable.

The Kansas Medical Golfing Association held its annual tournament in spite of the rain and there were prizes for many participants, including a few who, we suspect, are better doctors than golfers. The tournament banquet and other competitive sports concluded the first day.

The scientific programs were presented by a group of distinguished guest speakers. One address by Dr. A. C. Ivy, entitled "Jaundice: the Differential Therapeutic Approach," contained some valuable information which we are quoting for the benefit of those who did not carry paper and pencils to the meeting. Dr. Ivy believes that the important decision to make in a jaundice patient is to determine if he is to be treated medically or surgically. He presented the following criteria.

"Operation for jaundice is justified if (after the patient is properly prepared)

1. Having recently had colic pain with
  - (a) Change in color of urine and feces
  - (b) Absence of x-ray evidence of carcinoma of G. I. tract
  - (c) Absence of myocardial infarction, or
2. Persistent evidence of obstruction of biliary tract with
  - (a) Urine and stools negative for urobilinogen for more than three or four days (less than 5 mgm. of urobilinogen in feces in 24 hours)
  - (b) With or without pain
  - (c) With or without x-ray evidence of deformity of duodenal loop, or
3. Following laboratory tests normal (during first 2-3 weeks)
  - (a) Galactose tolerance test
  - (b) Hippuric acid excretion test
  - (c) Cephalin flocculation test."

Dr. W. M. Mills of Topeka was inaugurated president, succeeding Dr. W. P. Callahan of Wichita. Kansas medicine is fortunate to have the services of Doctors Callahan and Mills at a time when real leadership is essential if medicine is to maintain its independence against the persistent efforts of powerful political and economic groups to bring about the complete or partial socialization of the profession. Doctors Callahan and Mills have already developed Kansas Physicians' Service and a state medical society veterans' medical care program which may serve as a model program for the nation.

Dr. L. S. Nelson of Salina is the president-elect. Dr. P. W. Morgan of Emporia, just out of his soldier

suit and fresh back from the E.T.O., was elected A.M.A. delegate replacing Dr. J. F. Hassig of Kansas City.

Rev. Alphonse M. Schwitalla of St. Louis University School of Medicine spoke at the annual banquet. Rev. Schwitalla discussed medicine in current federal legislation with special reference to the A.M.A. ten-point program.

The ladies also had their day. The medical assistants held their annual meeting April 21 and 22. The Woman's Auxiliary enjoyed the hospitality of the Wichita auxiliary group throughout the session.

Six hundred twenty-nine members of the society enrolled at the session. There are 1,378 members, active and honorary, in the state society. We believe this is a new high mark for attendance.

### Child Health Survey

In view of present agitation concerning plans for medical care, it seems very fitting that the pediatricians in Kansas and throughout the United States have decided at this time to assume their share of responsibility for obtaining factual knowledge concerning child health. For, in spite of the agitation, no one really has facts to submit, so it is fitting that the ones who give this care, the doctors, dentists, and hospitals, should make the facts available.

Accepting the challenge to evaluate activities and make plans in its own field, the American Academy of Pediatrics has launched a nation-wide study of child health services as a first step toward the achievement of its postwar objective, "to make available to all mothers and children in the U. S. all essential preventive, diagnostic and curative medical services of high quality which, used in cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens."

The study is being organized on a state basis with the state chairmen of the academy serving as coordinators for the individual state programs. A test study has been completed in North Carolina, as a dress rehearsal for other states. The cooperation received, as shown by the very gratifying returns from the pilot state, indicates that interest in the study is keen and that pediatricians and physicians are fully aware of the importance of the project to themselves and their communities.

Kansas has already undertaken its share of responsibility under the able direction of Dr. E. G. Padfield, state academy chairman for the study in Kansas. Preparations for the collection of the necessary data are well under way and approval of

the study has been given by the Kansas Medical Society.

Information for the study will be sought from pediatricians, physicians and dentists in private practice; from hospitals and other institutions; from official and voluntary health agencies; and from medical schools and colleges. Basic data will thus be obtained on all aspects of medical and health care for children. This data will be made available to all interested groups as a sound basis on which improvements in community facilities and services can be developed where needed.

The pediatricians of Kansas have committed themselves to do a thorough job of fact-finding in order that we may learn exactly where we now stand in providing essential medical care for our children. The collection of the vast amount of data required represents a tremendous undertaking, an undertaking which concerns every physician and every person who contributes to our child care program. Special one-page schedules have been carefully prepared for distribution to physicians engaged in private practice in this state in order that they may contribute their share of information to the study. The questions included have been reduced to an essential minimum and the information requested can be supplied only by the physician himself. The contribution of physicians is of major importance to the successful completion of the study in Kansas and in the rest of the country. The evident need for such a study at this time warrants the full co-operation of every individual approached in the process of its completion.

### Refresher Courses at K.U.

Several new refresher courses have been announced recently by the School of Medicine of the University of Kansas as part of the program sponsored by the university in cooperation with the Kansas Medical Society and the Kansas State Board of Health. All courses are presented in Kansas City, Kansas. Complete information and programs may be secured from the University Extension Division, University of Kansas, Lawrence.

A course in general surgery and radiology is being presented this month, May 13 to 17, inclusive. In addition to members of the university faculty, there are several guest instructors, Major General Norman T. Kirk, MC, Surgeon General of the United States Army; Victor E. Chesky, M.D., chief of surgical section, Hertzler Clinic, Halstead; Sumner L. Koch, M.D., associate professor of surgery, Northwestern University, Chicago; W. A. Altmeier, M.D., department of surgery, University of Cincinnati, Ohio; L. R. Sante, M.D., professor of radiology, St. Louis University School of Medicine.

A course in obstetrics and gynecology will be presented June 17 to 21, inclusive, and a new plan will be adopted for a series of courses in surgical pathology extending from May 9 through July 25. The latter course consists of a full day program on Thursdays throughout the period.

# 87th Annual Session

APRIL 22-25, 1946—WICHITA, KANSAS

The 87th annual meeting of the Kansas Medical Society was held at Wichita, April 22-25, 1946. Six hundred twenty-nine doctors registered at this meeting, which brought the total attendance very near to the highest figure ever recorded in Kansas. Including the Auxiliary, medical assistants, exhibitors and guests, 1,239 persons were registered at this meeting, which total compares very favorably with total registrations for any meeting prior to the war.

The meeting began with a golf tournament played in



Approaching the commercial exhibits at the 87th annual session.

the rain. The golf dinner that evening celebrated the events of the day and also the occasion at which a beautiful watch was presented to E. S. Edgerton, M.D., Wichita, for low gross score. Other prizes were also given for various flights and special awards.

Scientific sessions began on Tuesday in both the general assembly and the E.E.N.T. section. Outstanding guest speakers from all parts of the United States appeared on the program. All sessions were well attended and after each paper enthusiastic comments were heard, proving the interest held by Kansas physicians in medical advancements.

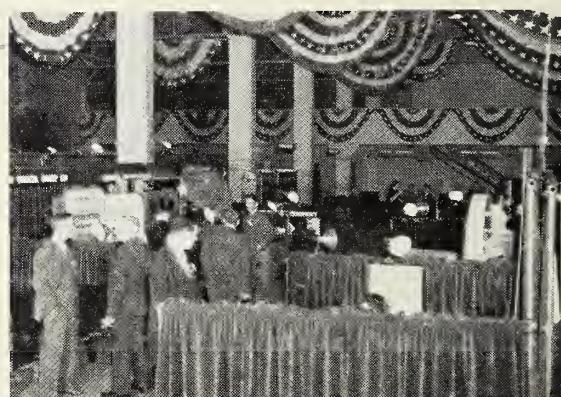


A section of the commercial exhibit room.

Scenes of the exhibit room are shown on these pages. More technical exhibitors attended this session than in any meeting held in the past. The large number of physicians congregating at all the booths during intermission was indicative of the interest shown in the technical exhibits. Attractive burgundy velour drapes and chrome furniture supplied by the decorator gave this section of the annual meeting a distinction rarely equalled at meetings of this type.

Many scientific exhibits were also displayed by physicians from Kansas and from as far away as St. Louis, Chicago and New York. The scientific section contained much material never shown in Kansas before and attracted many doctors at all times.

Many special events were held during this time, but none exceeded in attractiveness or in dignity the annual banquet. Six hundred seventeen dinners were served. After a brief introduction of guests, Thurlow Lieurance played several of his original compositions which were thoroughly enjoyed by the audience. The climax of this evening came with the splendid talk by Rev. Alphonse M. Schwitalla, S.J. His brilliant analysis of medical legislation now before the Congress of the United States stands alone among the many and varied discussions that have taken place on this subject. His tribute to the profession for organizing voluntary pre-paid medical care programs



Midway through the commercial exhibit section.

was heartening to the physicians of Kansas who have recently offered Kansas Physicians' Service to the people of this state. The evening was completed with dancing.

A visit from Col. James C. Harding represented another memorable event on this occasion. Dr. Harding spoke to the general assembly on plans now being made by the Surgeon General of the Veterans' Administration and his staff, of the need for cooperation from the medical profession, and of his gratitude to the Kansas Medical Society for its participation in the medical care program for veterans.

All features regularly included in the annual sessions of the Kansas Medical Society were presented at this first post-war session. A full program of round table luncheons was scheduled and each was well attended. Reports indicate that these occasions produced many active discussions.

A full schedule of scientific motion pictures was shown throughout the meeting, during all intermissions and at noon. Several committees used this occasion as an opportunity to hold meetings.

The Kansas Medical Society wishes to extend its gratitude to the Sedgwick County Medical Society for the splendid way in which this organization prepared the meeting and served as hosts. All events proceeded as scheduled and in spite of many unusual difficulties the annual session was conducted as smoothly as any in the past when circumstances were normal. Credit for this success is largely due to the careful planning which was directed by J. L. Kleinheksel, M.D., president; J. E. Wolfe, M.D., general chairman; the chairmen of all special committees; committee members, and the entire society.



General view of commercial exhibit section from the balcony.

In 1947 the annual session will be held in Topeka. Plans are already in progress for the next meeting. Exhibits and general sessions will be held in the Municipal Auditorium, although the dates are still tentative. The plan is now that the 88th annual session will be held in May from the 12th to the 15th, 1947.

Next year should complete the reconversion period and with the return of a normal economy the annual session will be of greater importance than ever.



The Coca-Cola booth in the center of the exhibit section.

## *Special Train to Annual Meeting*

# of The American Medical Association SAN FRANCISCO, CALIFORNIA

July 1-5, 1946

Sponsored by Oklahoma State  
Medical Association

A special train to San Francisco, carrying only doctors and their families, is being organized by the Oklahoma State Medical Association. This train, consisting of the finest equipment, will pass through Kansas and anyone planning to attend the A.M.A. meeting is invited to take advantage of this offer.

You will travel to a medical meeting in comfort and with congenial company. You will be spared the annoyances that often attend making reservations, changing trains, meeting schedules. You may combine your trip to the A.M.A. with a real vacation, and in this offer you can budget in advance exactly what you may expect to spend.

The special train will begin at Chicago, pass through Kansas, and proceed directly to San Francisco. Your hotel reservations in San Francisco are made for you and even travel from the station to the hotel is provided. At the close of the convention this train will take you on a vacation tour through the northern Rockies, stopping at points of interest, including Yellowstone National Park. You will return to the point where you boarded the train. The total trip including the time at San Francisco will take 14 to 16 days.

A ticket on this special train will include all costs for the entire period except meals. Hotel bills at San Francisco and at points of interest are paid for in the price of the fare. Taxi fares are included. So are tips all along the way. The only additional expense for any part of this journey is for your meals.

The price is surprisingly low. The advantages are great. The convenience is a factor that will be of special interest. You are welcome to include your entire family and you will have reservations in San Francisco for all in your party.

Dick Graham, executive secretary of the Oklahoma State Medical Association, states that reservations are coming in rapidly. To assure a place on this tour, write Dick Graham directly or send your letter to this office from where it will be forwarded. Write the Kansas Medical Society, 406 Columbian Building, Topeka, Kansas.

## EXECUTIVE OFFICE

*Editor's Note—Printed below is the report of the Executive Secretary given before the House of Delegates of the Kansas Medical Society at the first session of the 1946 meeting, April 22, 1946.*

Today we honor the return of those many physicians who voluntarily left their practice to enter the armed forces. These, some four hundred medical officers from Kansas, have made a contribution to the Kansas Medical Society that shall forever remain the most glorious chapter in its long line of enviable achievements. And now that they are back in practice again or are returning, the Society looks to these men for active participation in all its functions, to leadership in its endeavors and to guidance in its policies.

This review shall be an attempt to present to the medical officers from this state a picture of what the Society has experienced during their absence.

Pressures were exerted upon civilian members from many directions at exactly the time when they were least able to cope with them and under circumstances that could not be ignored. Those who attempted to reduce the standards of medical care in this state used the physician shortage to advantage in their accelerated efforts, but to this moment have not been successful. Those who aspire to revise the economy of this nation by yoking the people to a system of compulsory socialization have also deliberately, it seems, selected these war years for attacking with increased vigor. Their efforts also have largely met with failure. The most telling blow was the Emergency Maternal and Infant Care program which rolled in on an irresistible wave of patriotism and left your Society no alternative but to bow before its pressure. This program still exists and represents a major problem that must be faced and settled in one way or another—soon.

But Society activities have by no means been confined to the defensive. Civilian members are proud of the post-graduate education fund that was donated as an expression of gratitude toward those who entered the armed forces. They want this money used and sincerely hope it will be of benefit.

Kansas Physicians' Service has become a reality after innumerable hours of work were spent in preparation. This voluntary prepaid medical care plan is the first tangible answer the Society has found for advocates of socialization. It is a new enterprise, a service to the people of this state that stands apart from any previous activity in which the Society has been engaged.

Your agreement with the Veterans' Administration, the most recent among large scale Society activities, will one day be recorded in the history of your achievements as an epoch. The integrity of the Veterans' Administration has been repeatedly demonstrated, their interest in this venture is unquestioned, the cooperation of both General Hawley and Colonel Harding, often at considerable personal sacrifice, has been complete. This plan to aid the Kansas veteran is again a service project. It will succeed to the mutual benefit of all concerned, if we determine that it shall.

Both Kansas Physicians' Service and the veterans' plan were placed into action during this past year. For the former, Dr. Barrett A. Nelson has been the directing genius; for the latter, your president. Many others have contributed widely toward the determination of policy and deserve recognition. Past presidents have spent many hours in planning for the prepaid medical care program. The

executive committee of Kansas Physicians' Service, consisting of Dr. Nelson, Dr. Lattimore, Dr. Mills and Dr. Davidson, meets one long evening each month for this work. The Board of Directors, including sixteen doctors and two laymen appointed by the Governor, has been of tremendous value to this organization. Not only they, but individual physicians from all parts of the state have contributed through their suggestions and cooperation.

The Kansas Medical Society owes a great debt of gratitude to the Council. On many occasions when the temptation to be absent must have been strong, councilors drove hundreds of miles to attend meetings. The seriousness of their deliberations, the interest they have in your Society, the high ideals they hold for medicine are an inspiration to those of us who work for you.

Your president, Dr. W. P. Callahan, hardly needs comment because wherever the Veterans' Administration agreement is mentioned Dr. Callahan's term of office will be recalled. It was his initiative and determination that made this program successful. As certainly as any Society effort can be considered the result of one man's work, this program is Dr. Callahan's, and yet many others contributed, including again the Council and four hundred doctors who helped prepare the fee schedule.

During this memorable year, Dr. Callahan has given far more money and time to the Society than is generally known. Although the veterans' agreement is the event that possibly will best be remembered, it should be known that Dr. Callahan has been personally interested in every activity. Some will recall the drafting panel. You will hear more of that again in the near future. That was Dr. Callahan's project. He is a charter member of the Conference of Presidents, a national organization formed during the past year. Dr. Callahan has taken a large interest in the formation of the Graduate School at the University of Kansas and has constantly advised with us in the executive office.

A report of the past year should contain other items such as a review of conferences that were attended, a survey of the health measures that have appeared before the Congress of the United States, a review of the activities and the problems that confronted the State Board of Health, and specific items such as our county society tax problems, the narcotics situation, trends now predictable regarding locations and various activities in the field of public relations. All the above items have been discussed in the Journal and will not be repeated at this time.

This report, however, should not be concluded without mention of Clarence Munns. His return from service brought him directly back to the medical profession. His advice has many times been of great assistance to us in the executive office. His service to the Society is today as valuable as it was during the years he worked as your executive secretary. I know of many times where his interest in your work and where his experience with your problems prompted him to perform services for the Society since his return—services that were entirely apart from and of no value to the business in which he is now engaged. Clarence does these things quietly, but we want you to know that he is still serving your interests before his own.

This in brief is your Society at the close of the war. We are now entering a new period in the history not only of our nation but of the practice of medicine. To reach the conclusion of this period with satisfaction we will all need to cooperate in constructive activities. Toward that end, attempting to perform according to your wishes, we in your executive office pledge our sincerest efforts.

## KANSAS PHYSICIANS' SERVICE

All forms pertaining to Kansas Physicians' Service have arrived from the printer and were mailed to the membership within the past month. Each doctor in the Kansas Medical Society now has received a copy of the Subscription Agreement, the Physicians' Service Report, and the Schedule of Benefits. These items should be filed for permanent reference since they apply to work Kansas physicians will do for subscribers to the plan. If any member has failed to receive this material, he is requested to write the Executive Office, Kansas Medical Society, 406 Columbian Building, Topeka, Kansas.

In the Schedule of Benefits is contained, besides the amount to be paid for various procedures, a complete set of instructions concerning the operation of this plan. Each doctor is requested to read these instructions, thereby becoming familiar with policies covering Kansas Physicians' Service. This will prevent future possible misunderstandings not only between participating physicians and the corporation but also between subscribers and the individual physician rendering service under the subscription agreement. If there remain any doubts or questions, inquiries are welcomed and every attempt will be made to supply whatever answers are required.

The annual meeting of the Board of Directors of Kansas Physicians' Service, as provided in the by-laws, was held at Wichita on April 22, 1946, at which time various decisions made previously by the Executive Committee were approved. Many pertained to academic matters but those items that seem to hold general interest will be outlined here for the information of the membership.

For instance, to avoid possible confusion between material issued through the Kansas Medical Society or through the Blue Cross, since both organizations use blue ink, in the future all material from Kansas Physicians' Service will appear in brown.

Another problem was that of enrollments in Kansas City, Kansas. Since this area is presently covered by Kansas City Surgical Care, Incorporated, it was considered advisable to arrive at an equitable decision with that organization before enrollment in the Kansas City area should be attempted.

The wording on official documents has been altered in several places since the date of the last board meeting, which items were discussed and approved. Under this category comes a clarification in the Subscription Agreement whereby persons under the service contract are not limited to the number of services that may be rendered, although physicians are limited as to amounts that may be paid. The word "functional," previously one of the exclusions in the contract, has been deleted and will not appear in subsequent printings.

An important change in policy has been made regarding veterans. Veterans are eligible to join Kansas Physicians' Service on an individual basis if enrollment is made prior to July 1, 1946. Thereafter, veterans may enroll as individual members within 60 days following discharge from service. At present the veteran, with his family, is the only person who may enroll without entering with a group.

At present 709 doctors are enrolled as participating physicians, which represents a growth of 125 participating physicians within the past two months. Enrollment figures have not been accurately tabulated, but have reached approximately 5,000 members subscribing at present. There

have been approximately 30 claims for services rendered paid to date.

On this occasion an election was held, at which time all officers and directors were re-elected for another year, with the exception that Dr. Dale D. Vermillion, Goodland, replaced Dr. Burl V. Thompson for the Ninth District, which vacancy occurred when Dr. Thompson moved into another district, and the change in the president of the Kansas Medical Society.

The Board of Directors for the coming year is composed of the following:

Barrett A. Nelson, M.D., President.....	Manhattan
John L. Lattimore, M.D., Vice President.....	Topeka
Oliver E. Ebel, Executive Vice President.....	Topeka
W. M. Mills, M.D., Secretary-treasurer.....	Topeka
C. H. Benage, M.D.....	Pittsburg
W. F. Bernstorf, M.D.....	Winfield
R. R. Cave, M.D.....	Manhattan
O. W. Davidson, M.D.....	Kansas City
Frank Foncannon, M.D.....	Emporia
G. R. Hastings, M.D.....	Garden City
O. A. Hennerich, M.D.....	Hays
Holmes Meade .....	Topeka
F. G. H. Meckfessel, M.D.....	Lewis
L. S. Nelson, M.D.....	Salina
R. T. Nichols, M.D.....	Hiawatha
E. M. Sutton, M.D.....	Salina
M. F. Trued.....	Topeka
M. Trueheart, M.D.....	Sterling
Dale D. Vermillion, M.D.....	Goodland

### K.P.S. Exhibit

At the 87th annual session of the Kansas Medical Society two booths were devoted to Kansas Physicians' Service and Blue Cross. Large permanent display boards were constructed for this purpose and will be available in the future to organizations wishing to set up displays for either Kansas Physicians' Service or Blue Cross. Members of the sales organization, including the director of sales, were in the booth throughout the annual session and reported that many physicians stopped to inquire about the new pre-paid medical care plan sponsored by the society.

At this meeting Kansas physicians had their first opportunity to visit with employees of the corporation to discuss details of the plan. Discussions also included inquiries on ways in which groups might be formed. During the three days that this exhibit was displayed to the physicians of Kansas, 30 additional doctors became participating physicians and many others received answers to questions that had not been satisfactorily supplied by mail.



Kansas Physicians' Service and Blue Cross exhibit at the 87th annual session.

# *Official Proceedings - - House of Delegates*

## First Session, House of Delegates

April 22, 1946

The meeting opened with the call to order by the president, Dr. W. P. Callahan.

The first order of business was a call for the reading of the minutes. It was moved by Dr. F. R. Croson, duly seconded, that the minutes printed in the Journal of the Kansas Medical Society be accepted in lieu of the reading of the minutes. Motion carried.

Dr. A. W. Fegley announced a quorum present and the meeting proceeded.

Dr. L. S. Nelson gave the report of the reference committee on councilor reports. He stated in part: "I think I speak the sentiments of the council in saying that each problem has been weighed with all the available evidence and decisions announced with humility. The various members have sought the opinions of the physicians of their respective districts and endeavored to represent their constituents. If mistakes have been made they have been 'errors of the head and not the heart.' May we hope for a continued strong grip on our problems to the end that Kansas medicine may progress scientifically and as an intelligent social force in each community." It was moved by Dr. O. O. McCandless, duly seconded, that this report be accepted. Motion carried.

Dr. C. R. Rombold reported for the reference committee on committee reports. Dr. C. C. Nesselrode spoke of the importance of the establishment of cancer detection units in local county medical societies. There was some discussion of this subject, after which it was moved by Dr. O. O. McCandless, duly seconded, that this report be accepted. Motion carried.

Dr. A. W. Fegley read amendments to the by-laws which had been printed in the Journal. These were tabled until the next meeting.

Dr. G. G. Whitley presented the following resolution of the Butler County Medical Society:

"BE IT RESOLVED: That the Butler County Medical Society, being convened in regular session on the eighth day of March, 1946, did approve unanimously and does hereby petition the House of Delegates for a charter for said medical society.

"The revised constitution and by-laws of the Butler County Medical Society are now on file with the executive secretary of the Kansas Medical Society." Signed G. G. Whitley, M.D., Delegate.

Dr. F. C. Basham read the following resolution of the Greenwood County Medical Society:

"April 6, 1946. WHEREAS: The Greenwood County Medical Society is not a component of the Kansas State Medical Society, and whereas: this society unanimously desires such affiliation, therefore

"BE IT RESOLVED that we request a charter from the Kansas Medical Society as a component unit." Signed, John H. Basham, M.D., president; James Basham, M.D., secretary; C. D. Baird, M.D., and F. C. Basham, M.D.

It was moved by Dr. C. C. Nesselrode, duly seconded, that the resolutions be approved and the charters be granted. Motion carried.

Dr. E. G. Padfield reported that the American Academy of Pediatrics in 1944 decided that since they had very little information on child health a survey should be made of the entire United States. This program will have assistance from the United States Public Health Service and the Children's Bureau of the Labor Department.

The following resolution was presented by Dr. L. B. Gloyne for the Wyandotte County Medical Society:

"WHEREAS, The constitution and by-laws provides that the House of Delegates shall meet on the first and on the last day of each annual session, therefore,

"BE IT RESOLVED, That beginning with the year 1947, the House of Delegates meet either during the late afternoon or evening of the first day of the full scientific program and the morning of the last day of the full scientific program."

The report of the Editorial Board was read by Dr. W. M. Mills. At the close of this report Dr. Mills announced his resignation as editor of the Journal. Dr. C. C. Nesselrode moved that this report be accepted and placed on file and that the Editorial Board be given a vote of confidence and appreciation for their efforts. This was duly seconded and the motion carried.

Mr. Oliver E. Ebel read the report of the executive secretary.

Dr. F. R. Croson gave the report of the constitutional secretary, showing present membership of the Society as 1,378.

The treasurer's report was read by Dr. J. L. Lattimore.

Dr. J. F. Hassig and Dr. F. L. Loveland reported as delegates to the American Medical Association. A new scientific group on general practice has been established. Dr. Olin West, secretary of the American Medical Association, has been replaced by Major General George F. Lull, formerly of the Surgeon General's office.

Dr. J. L. Lattimore reported briefly on the situation confronting Blue Cross.

Dr. B. A. Nelson reported on the progress of Kansas Physicians' Service, which has been in actual operation since January 1, 1946, with approximately 6,000 subscribers having signed and over 700 physicians participating. No other plan has reported such a high percentage of physicians signed up at the start of their program. He reported on the national organization recently set up through the American Medical Association and asked for continued support.

There was no new business.

Dr. Callahan announced the expiration of four councilors' terms of office and the members from those districts were asked to meet and prepare the proper report of election at the next session.

The time of the next session of the House of Delegates was announced, to be held at the Forum instead of the Allis and to convene immediately after the last speaker had finished.

There being no further business, the meeting adjourned.

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## Second Session, House of Delegates

April 25, 1946

The meeting was called to order by the president. Dr. A. W. Fegley reported a quorum present.

A report of secondary meeting of reference committees was called for. None was given.

Under unfinished business, Dr. A. W. Fegley reported on the proposed amendments to the constitution and by-laws which were read at the first session.

The first, Constitution, Article II, Purposes of the Society, was approved. The second, By-laws, Chapter V, House of Delegates, Section 12, was approved. The third, By-laws, Chapter XI, Committees, Section 24, was ap-

proved. The fourth, By-laws, Chapter XI, Committees, was rejected.

Dr. E. G. Padfield's report of the proposed survey of child health conditions was approved. The State Board of Health was authorized to assist in this survey.

Dr. L. B. Gloyne spoke on the resolution he had presented at the first session regarding meeting time of the House of Delegates. After discussion, a motion was presented by Dr. A. W. Fegley that the resolution be tabled since the suggestions made by this resolution can be accomplished under existing by-laws. This was duly seconded and carried.

The president then proceeded to the election of officers. Dr. L. S. Nelson was nominated as president-elect. It was moved, duly seconded and carried, that the nominations be closed and the secretary be instructed to cast a unanimous ballot.

Dr. O. W. Davidson was nominated as first vice-president. It was moved, duly seconded and carried that the nominations be closed and the secretary be instructed to cast a unanimous ballot.

Dr. J. H. A. Peck was nominated as second vice-president. It was moved, duly seconded and carried that the nominations be closed and the secretary be instructed to cast a unanimous ballot.

Dr. F. R. Croson offered his resignation as constitutional secretary and nominated Dr. J. M. Porter. He also moved that nominations be closed and that the secretary be instructed to cast a unanimous ballot. Motion carried.

Dr. J. L. Lattimore was nominated as treasurer. It was moved, duly seconded and carried that the nominations be closed and the secretary be instructed to cast a unanimous ballot.

Dr. Phil Morgan and Dr. J. F. Hassig were nominated as delegates to the American Medical Association meeting. It was moved, duly seconded and carried that the nominations be closed. It was moved, duly seconded and carried by a standing vote of 32 to 25 that the nominations be reopened. Dr. Howard E. Snyder was nominated as delegate to the American Medical Association.

Dr. Callahan reported that the vote would be by written ballot and the low man would be dropped unless there was a majority. Tellers were appointed to collect and count the ballots. Dr. Morgan received a majority and it was moved by Dr. Hassig, duly seconded and carried, that the nominations be closed and the secretary be instructed to cast a unanimous ballot.

Dr. F. L. Loveland expressed a desire to resign either as of this year's session or for next year. Dr. M. Trueheart suggested that he remain in office as delegate at least through the coming session of the American Medical Association.

The next item of business was election of councilors. The delegates from the four districts involved, after holding separate elections, reported the following councilors elected:

Third District—Dr. C. H. Benage, re-elected for a three-year term until 1949.

Sixth District—Dr. W. F. Bernstorf, re-elected for a three-year term until 1949.

Tenth District—Dr. Murray C. Eddy, elected for a three-year term until 1949.

Twelfth District—Dr. G. R. Hastings, re-elected for a three-year term until 1949.

It was moved by Dr. L. F. Barney, duly seconded and carried, that a telegram expressing affection and best wishes be sent to Dr. George P. Gray. Mrs. Foster was instructed to do this.

Dr. Callahan presented the new president, Dr. W. M.

Mills, who responded with a brief message to the Society, asking the same whole-hearted cooperation that has been extended to Dr. Callahan.

Dr. Barney moved, duly seconded, that a rising vote of thanks be given to the members of the Sedgwick County Medical Society. Motion carried.

It was moved by Dr. Henry N. Tihen, duly seconded, that a standing vote of appreciation be tendered to Dr. Callahan for the fine work he has done during his year as president. Motion carried.

There being no further business, the meeting was adjourned.

## Officers and Councilors

Published below is a list of the officers of the Kansas Medical Society and the Council, which group becomes the governing body of the Kansas Medical Society during the next fiscal year. Decisions required in the interim between meetings of the House of Delegates will be made by this body.

President, W. M. Mills, M.D., Topeka

President-elect, L. S. Nelson, M.D., Salina

Past President, W. P. Callahan, M.D., Wichita

First Vice President, O. W. Davidson, M.D., Kansas City

Second Vice President, J. H. A. Peck, M.D., St. Francis

Secretary, John M. Porter, M.D., Concordia

Treasurer, J. L. Lattimore, M.D., Topeka

AMA Delegate, J. F. Hassig, M.D., Kansas City\*

AMA Delegate, F. L. Loveland, M.D., Topeka

## Council

First District, R. T. Nichols, M.D., Hiawatha

Second District, L. G. Allen, M.D., Kansas City

Third District, C. H. Benage, M.D., Pittsburg

Fourth District, Frank Foncannon, M.D., Emporia

Fifth District, John L. Grove, M.D., Newton

Sixth District, Warren F. Bernstorf, M.D., Winfield

Seventh District, R. R. Cave, M.D., Manhattan

Eighth District, Ben H. Mayer, M.D., Ellsworth

Ninth District, J. H. A. Peck, M.D., St. Francis

Tenth District, Murray C. Eddy, M.D., Hays

Eleventh District, John R. Campbell, M.D., Pratt

Twelfth District, G. R. Hastings, M.D., Garden City

\*Philip W. Morgan, M.D., Emporia, was elected to become delegate to the AMA from Kansas. His term of office begins in June, 1947, on the date of the opening of the first House of Delegates meeting. The term for this office is two years.

## Allocation of Streptomycin

The Army Medical Department, which has been receiving many requests for supplies of streptomycin, has announced that all civilian inquiries and requests for this drug are to be sent to Dr. Chester S. Keefer, Evans Memorial hospital, 65 East Newton, Boston. Dr. Keefer has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether or not streptomycin is indicated in the treatment of the case.

In addition to this distribution, streptomycin is also being allotted by the Civilian Production Administration to the Army, Navy, Veterans' Administration and the United States Public Health Service.

### Report of Journal Editor

At the first meeting of the House of Delegates Dr. W. M. Mills, editor of the Journal, reported on this phase of Society activities. He stated in part that 1,850 copies are mailed each month to members of the Society and other interested individuals and groups.

A larger volume of advertising has been obtained than during any previous year of publication. The bulk of Journal advertising, as formerly, is received through the Cooperative Medical Advertising Bureau, Chicago. Contracts for 1946 also call for the use of more color than has appeared in the Journal before. This increase in advertising has made it necessary to add more pages, and current issues include 64 or 68 pages in place of the 52-page editions printed in 1945.

Increased advertising, together with the increased cost of color printing, as well as higher publication costs, has materially raised Journal expenses during the past year. The volume of advertising carried by the Journal, however, has compensated for these charges so that during the past fiscal year the Journal has continued to be self-supporting. For a number of years the Journal has not asked for financial assistance from the medical society.

Among problems confronting the editorial board are continued paper shortages, but of greatest importance is the difficulty in obtaining suitable scientific material. Appeals have been made to the secretaries of county societies and to members who have contributed previously, but the scarcity of scientific papers remains. The editorial board has determined to publish a larger number of articles in each issue, but can do this only if the membership submits sufficient material of acceptable quality. Original papers, critical reviews of existing literature and case reports of unusual nature are acceptable and will be welcomed by the board. All members of the Kansas Medical Society are urged to submit material for publication.

At the conclusion of the report Dr. Mills submitted his resignation to the House of Delegates and stated that he would later ask the Council to appoint his successor.

### COUNTY SOCIETIES

Dr. Daniel Petersen, Herington, was elected president of the Golden Belt Medical Society at a meeting held April 4 at Junction City with members of the Geary County Society as hosts. Dr. L. S. Steadman, Junction City, was named vice-president and Dr. L. E. Eckles, Topeka, secretary.

A scientific program was presented during the afternoon with approximately 50 doctors in attendance. Dr. Henry S. Blake, Topeka, spoke on "The Use of Whole Blood and Blood Plasma," Dr. W. J. Feehan, Kansas City, discussed "External Pin Fixations of Fractures," Dr. Frederick B. Campbell, Kansas City, Missouri, presented colored slides to illustrate a paper on "Interesting Cases of Anus, Rectum and Colon," and Dr. Donald N. Medearis, Kansas City gave a paper on "Treatment of Purulent Meningitis in Children."

An informal program and business session followed a seven o'clock dinner.

\* \* \*

The April meeting of the Saline County Society was held on the 18th at Cafe Casa Bonita, Salina. Dr. Graham Asher and Dr. Tom R. Hamilton, Kansas City, Missouri, were guest speakers, presenting papers on "Pulmonary Embolism" and "Medical Pathologic Aspects in Relation to Treatment."

Members of the Central Kansas Society met March 14 at St. Anthony's hospital, Hays. Dr. John C. Mendenhall, Denver, spoke on "Hypertension" and Dr. Vernon G. Jeurink, also of Denver, discussed "Ulcerative Colitis." A dinner at the Lamer hotel, with members of the Auxiliary as guests, followed the scientific program.

\* \* \*

The Wilson County Society and Auxiliary enjoyed a dinner at the Stoner Coffee shop, Fredonia, on March 29, after which the two groups held separate meetings. At the business meeting for the doctors, held in the office of Dr. Lynn Beal, Mr. Lloyd Bliss, welfare director for the county, discussed a contract and fee schedule for the care of the indigent and those on old age pensions.

\* \* \*

Dr. R. J. Metcalf and Dr. H. N. Overholser presented case discussions on meningitis and Dr. R. M. Brian spoke on x-ray findings at the regular meeting of the Butler County Society on March 8 at El Dorado. The constitution of the society was revised and approved at the business session.

\* \* \*

The Cherokee County Society met at the country club at Columbus on March 19 with all members present. Guests attended from Crawford and Labette counties and from Miami, Oklahoma, with members of the legislature from Cherokee county as special guests. Dr. J. L. Lattimore, Topeka, spoke on the Rh factor and Mr. Oliver Ebel, Topeka, executive secretary of the Kansas Medical Society, discussed medical legislation and Kansas Physicians' Service.

### ANNOUNCEMENTS

The annual meeting of the American College of Radiology will be held in San Francisco on June 29, 1946, with headquarters at the Palace hotel. This date is the Saturday preceding the meeting of the American Medical Association. The American Radium Society will meet during that week also, June 30 and July 1, at the same hotel.

Hotel reservations will not be made through the College, but may be requested through the Sub-committee on Hotels, A.M.A. Convention, Room 200 Civic Auditorium, San Francisco 2, California.

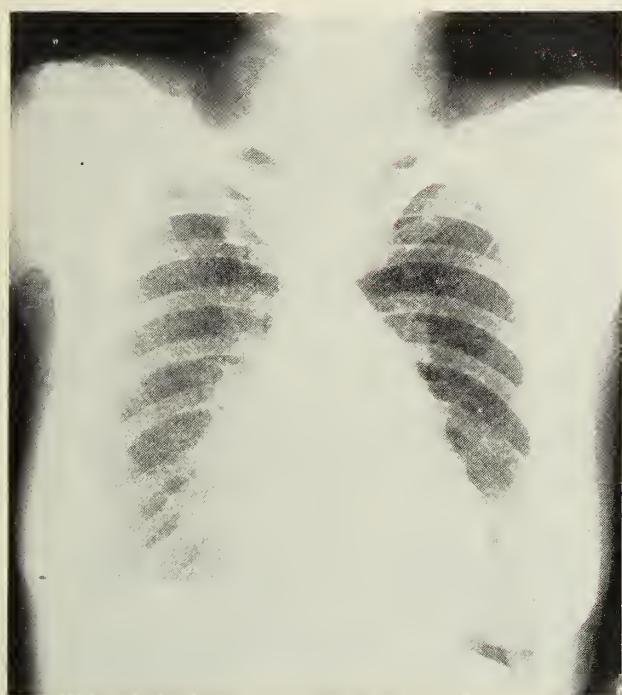
\* \* \*

The American Congress of Physical Medicine will hold its 24th annual scientific and clinical session September 4-7, inclusive, at the Hotel Pennsylvania in New York. All sessions will be open to members of the medical profession in good standing with the A.M.A. In addition, an instruction course will be held September 4-6, open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians. Complete information may be secured from the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

\* \* \*

The School of Medicine of the University of Kansas has announced a refresher course in obstetrics and gynecology to be given at the University of Kansas Medical School June 17-21, 1946. A stipend of \$60 will be paid by the Kansas State Board of Health to a limited number of physicians attending this course. Physicians who plan to use this stipend should apply to the Kansas State Board of Health at an early date. Preference will be given veterans, and other applications will be accepted in the order in which they are received.

## congestive heart failure



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## DEATH NOTICES

### JOSEPH J. MICHALAK, M.D.

Dr. Joseph J. Michalak, 50, of Humboldt, died at an Iola hospital February 3, after an illness of only a few days. He was an active member of the Allen County Medical Society. A graduate of the St. Louis University School of Medicine in 1919, he practiced in Omaha and in Kansas City for short periods before opening his office in Humboldt almost 25 years ago.

\* \* \*

### HIRAM TRUMAN JONES, M.D.

Dr. Hiram T. Jones, 72, who had practiced in Lawrence for 46 years, died February 6 at Lawrence Memorial hospital. He was graduated from University Medical College, Kansas City, in 1899 and immediately opened his office in Lawrence. He was an active member of the Douglas County Medical Society and had served as its president. Since 1933 he had been practicing in partnership with his son, Dr. H. Penfield Jones, except for a period of three years while the younger Dr. Jones served in the Army medical corps.

\* \* \*

### THOMAS S. FINNEY, M.D.

Dr. Thomas S. Finney, 52, an active member of the Sedgwick County Medical Society, died at Wichita January 29. A 1919 graduate of the Johns Hopkins University School of Medicine in Baltimore, he had practiced in Wichita for many years.

\* \* \*

### RICHARD S. PICKLER, M. D.

Dr. Richard S. Pickler, 61, a member of the Mitchell County Medical Society, died at his home at Beloit February 23. He was graduated from Creighton University Medical School in 1912 and had practiced in Beloit for many years.

\* \* \*

### ARTHUR J. LIND, M. D.

Dr. Arthur J. Lind, 66, Kansas City physician specializing in internal medicine, died March 2 at his country home north of Bonner Springs. A graduate of the Kansas City College of Physicians and Surgeons in 1901, he had practiced in Kansas City since that time. He was a member of the Wyandotte County Medical Society.

\* \* \*

### HARVE M. STRICKLEN, M. D.

Dr. Harve M. Stricklen, 65, active member of the Cowley County Medical Society, died at Arkansas City April 5. He was a graduate of the University Medical College of Kansas City and had practiced first in Tonkawa, Oklahoma. He moved to Arkansas City in 1928 and there built the Stricklen hospital. During World War I he served in the Army Medical Corps.

\* \* \*

### THOMAS P. HASLAM, M. D.

Dr. Thomas P. Haslam, 62, died at an Emporia hospital April 15. A graduate of the University of Nebraska College of Medicine, Omaha, he had practiced in Council Grove for many years, operating the Haslam clinic and specializing in radiology. He was a member of the Morris County Medical Society.

\* \* \*

## MEMBERS

Dr. John A. Dillon, Jr., who was recently discharged from the Army after five years' service, is now taking a postgraduate course in eye work at Harvard medical school. His home is in Great Bend.

\* \* \*

Dr. R. T. Unruh, a former member of the staff of the Hertzler clinic, Halstead, has opened an office in Kinsley.

\* \* \*

Dr. C. V. Minnick returned to his practice in Junction City last month after being released from the Army. He entered the service in 1943 and was on duty in the Pacific theater for 20 months.

\* \* \*

Dr. L. L. Wenke, Great Bend, who was recently released from the Army, has enrolled at the University of Oregon Medical School for six months or more postgraduate work.

\* \* \*

Dr. Lottie F. Law, who has been practicing in Hill City for approximately 40 years, has announced her retirement.

\* \* \*

Dr. L. W. Hatton has returned to his practice in Salina after several years' absence while serving in the Army.

\* \* \*

Dr. Ray Meidinger, who has been practicing in Highland, has announced the opening of an office in Hiawatha.

\* \* \*

Brigadier General William C. Menninger, Topeka, director of the Neuropsychiatry Consultants Division, Office of the Surgeon General, has been awarded the distinguished service medal for the primary responsibility for "solving one of the most serious medical problems faced by the Army" in developing and putting into effect a treatment plan for neuropsychiatric cases; according to an announcement from the Office of the Surgeon General.

\* \* \*

Dr. Ralph G. Ball, who has been serving in the Army for the past four years, was released from the service with the rank of colonel and has now resumed his practice in Manhattan.

\* \* \*

Dr. Harry O'Donnell, who has been serving in the Navy medical corps, 21 months in the Pacific, returned to civilian practice in Junction City last month. He is associated in practice with his father, Dr. A. E. O'Donnell, and his uncle, Dr. F. W. O'Donnell.

\* \* \*

Dr. C. N. Petty, Altamont, recently observed his fiftieth anniversary in the practice of medicine.

\* \* \*

Dr. R. E. Baldridge has returned to his practice in Kingman after several years absence while serving with the Army in the ETO. He was discharged with the rank of major.

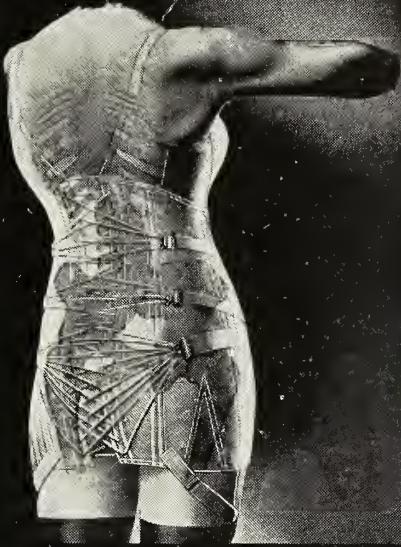
\* \* \*

Dr. L. M. Schrader, who has been practicing in Kinsley for many years, has announced his retirement.

\* \* \*

Dr. Harold F. Spencer, who practiced in Garnett before entering the Navy medical corps in August 1942, has announced the opening of an office in Emporia. At the time he was released from the service he held the rank of lieutenant commander.

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Dr. Louis Cohen has announced the opening of an office in Topeka after 42 months service as a major in the Army medical corps. He was formerly assistant instructor in physiology and medicine at the University of Kansas School of Medicine.

\* \* \*

Dr. J. D. Colt, Sr., who retired January 1 after 50 years of practice, was honored by the Manhattan Rotary club at a luncheon on February 14. Members of the Riley County Medical Society were guests, introduced by Dr. J. D. Colt, Jr. Dr. R. R. Cave spoke on behalf of the county society and Mr. Oliver Ebel and Mr. Clarence Munns, both of Topeka, spoke for the state medical society.

\* \* \*

Dr. R. E. Bennett, who has been serving in the Army, has reopened his office in Beloit.

\* \* \*

Dr. C. D. Kosar, who served as a lieutenant colonel in Army hospitals at Camp Hulen and Camp Hood, Texas, has been released from the service and has resumed his EENT practice in Concordia in partnership with Dr. Ellis Starr.

\* \* \*

Dr. Marion Trueheart, Sterling, appeared twice on the program of the Congress on Cancer held at Guadalajara, Mexico, February 6. His addresses were on cancer of the lips and mouth.

\* \* \*

Dr. William Brown has returned to his practice in Paola after having served in the Army for more than three years. While in the service he was stationed in the ETO.

\* \* \*

Dr. D. A. Bitzer, who was recently released from the Navy, has announced the reopening of his office in Washington.

\* \* \*

Dr. Paul E. Davis has been named acting superintendent of the state hospital for epileptics at Parsons, according to an announcement made recently by the state board of social welfare, filling the vacancy caused by the death of Dr. C. F. Davis. He had served as psychiatrist at the Larned hospital from 1936 to 1942, when he entered the Army medical corps.

\* \* \*

The Douglas County Medical Society has announced the return of nine of its members from the armed forces. Those whose return to civilian practice has not yet been reported in the Journal are Doctors Lyle S. Powell, R. A. Clark and T. R. Hood, all of Lawrence. Two members of the society, Doctors A. S. Anderson and Wray Enders, are still on active duty in the Army.

\* \* \*

Dr. Morgan Mollohan has announced the opening of an office in Seneca. He was recently released from the Army after 42 months' service.

\* \* \*

Dr. L. E. Filkin, who practiced in Junction City before entering the Army, plans to open an office in Concordia soon. During his 44 months' service, Dr. Filkin was assigned to divisions which took part in the whole European campaign.

Dr. Ben Boltjes, Manhattan, is now working toward a Ph.D. degree in bacteriology at the University of Pennsylvania, and his practice is being taken over by Dr. Warren W. Burns, who recently completed a postgraduate course in obstetrics at Harvard medical school.

\* \* \*

After three years' service in the Army Dr. Ralph White has returned to his practice in Garnett in the Hood-White clinic. Dr. T. A. Hood will continue to be a partner in the clinic but is now taking an extended vacation.

\* \* \*

Dr. G. W. Hay, a practicing physician in Parsons for 30 years, has announced his retirement, for the second time. He originally retired in January 1941, but returned to his practice two years later because a number of physicians in that locality were in the service, causing a shortage of medical care.

\* \* \*

Dr. W. T. Braun, who served with the Navy V-12 unit at K.S.T.C., Pittsburg, has announced that he will soon open an office in that city. He had formerly practiced in Memphis, Tenn., and while in the Navy had served in the Pacific for some time before being stationed in Pittsburg.

\* \* \*

Dr. C. L. White, who formerly practiced in Ellinwood has announced the opening of an office and clinic in Great Bend.

\* \* \*

Dr. T. V. Oltman, a member of the Axtell clinic, Newton, addressed the Newton Junior Chamber of Commerce at a meeting held January 30, on the battle of the Burma road. As a medical missionary in Japan, Dr. Oltman was interned there after the opening of hostilities, was later repatriated, and returned to the CBI theater to serve as a lieutenant colonel in the Army medical corps.

\* \* \*

Dr. B. V. Thompson, who has been practicing at Hoxie for the past five years, has joined the staff of the Hatcher hospital at Wellington.

\* \* \*

Dr. Lucius Eckles, who has been serving as a commander in the Navy at Great Lakes, Illinois, and Washington, D. C., has been discharged and has returned to his practice of pediatrics in Topeka.

\* \* \*

Brigadier General George S. Beach, Jr., formerly of Topeka, is one of three new assistants to the Surgeon General, nominated by President Truman to serve in that capacity for a four-year term. He has been a member of the regular Army medical corps since 1917 and has been commanding general of Brooke General Hospital, Fort Sam Houston, Texas, since 1917.

---

In considering the patient with a "surgical abdomen" one should take time before operation to ask himself: "What else could this be besides what I think it is?" This may save an unnecessary operation; it may prevent a hasty, injudicious approach to a major surgical problem.

Extra-abdominal conditions which may simulate abdominal surgical emergencies should be carefully ruled out; by the same token, the surgeon should be equally thorough in ruling out unsuspected intra-abdominal lesions after the abdomen is opened, once he finds that his preoperative diagnosis is in error.—Joel W. Baker, M.D., in Clinical Medicine.

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## THE KANSAS PRESS LOOKS AT MEDICINE

### Criminal Negligence

The people of Reno county are somewhat agitated on account of a threatened diphtheria epidemic and already some of the schools have been closed. They have reason to become excited. The only trouble is that they are excited several years too late.

There is no more reason why there should be any diphtheria in Reno county than in the adjoining Kingman county, yet in the latter county there has not been a death from diphtheria and there has been less than half a dozen cases in almost twenty years. During that time there has been no quarantine and no schools have been closed on account of diphtheria. What few cases there have been in the county were children who had moved in from other places. These isolated cases caused no worry or excitement because there were no other children in the county who could "catch" the disease and it was not necessary to even quarantine the afflicted family.

The condition which prevails in Kingman county could have been possible in every other county in the state. It was made possible here by the county commissioners paying a nominal sum to have all children vaccinated every two years, except those who had previously been vaccinated. In this way the source of supply is kept dried up before the disease gets started and it is no longer necessary for a doctor to try to keep some child from choking to death with diphtheria. On account of the fine cooperation of the doctors in the county, V. L. Cline, chairman of the board of county commissioners, states that it costs the county about \$400 every two years. Try to figure what the return is on that investment.

Not a child anywhere dies from diphtheria but whose life could have been saved. Diphtheria is no longer a disease—it's a crime and every case of it is proof positive that someone has been guilty of criminal negligence.—*The Kingman Journal*, January 25, 1946.

\* \* \*

### A Medical Plan

The state has a prepaid medical plan which, despite the rapid growth it has made since inception a month ago, is suffering from limited attention from the public and mediums of publicity through which the public gets its information.

The plan is incorporated under the name of the Kansas Physician's service and is the doctors' answer to federal control of medicine with all of its bureaucratic ramifications. At this point it appears to be an excellent answer, one that will fill all the demands made by proponents of federalized medicine without the attendant evils of bureaucracy.

Those persons enrolled in the physician's service pay 90 cents a month or \$2.25 for their entire family for insurance to meet expensive surgical operations or treatment of fractured bones—in other words the principal high cost items in the medical field. Office calls and a doctor's visit to the home do not come under the plan, although all accidents are covered regardless of where they may occur.

The existing private medical organizations, being somewhat human, are not perfect but any workable plan for reducing the load which arises from serious illness or accidents will be a thousand times more satisfactory than if the same service were to be performed under federal direction. The only regrettable feature is that the doctors

waited until threatened with federal control before acting in unison to attack an age-old problem.—*Parsons Sun*, February 5, 1946.

### Sedatives—A National Problem

If drug stores stopped selling sedatives for a period of two weeks there would be an awful lot of people on the night shift who couldn't sleep days and a lot on the day shift who couldn't sleep nights; then there would be some who weren't on any shift (shiftless) who couldn't sleep any time.

Everybody seems to be tired but nobody seems to know what to do after they get to bed. The old gag about being so tired they couldn't get to sleep, still is being heard—so they get up, have a cup of coffee, a sandwich, a cigarette, another sedative tablet, some mineral oil, and hop back in bed and start counting sheep till they get into the 100,000's and by that time it's almost morning—so they get up, read a few chapters of "Forever Amber" and then off to work

It is a good thing that there are still some drugs that have to be obtained by prescription to protect those people who are trying to avoid rigor mortis by taking alternate doses of synthetic sedatives and stimulants. A sedative taken at night often has a "hangover" effect the next day so that the person is not sure he's alive till late in the morning, and wonders why he is so tired after such a good night's sleep.

The most common reason for the prescribing of sedatives is a wastebasket term called "nervousness." An interesting group of slang synonyms has arisen from this hackneyed complaint; heebie-jeebies, jitters, shakes, willies, jumps, frazzled, twidgley, skittery, going all to pieces, blowing one's top, going haywire, going berserk, ad infinitum.

The central nervous system apparently is taking a terrific pounding with the so-called advance of civilization, but as long as chemical depressants are available as easily as they are now, there is very little hope for the future. Perhaps physicians prescribe sedatives too often for minor transient insomnia, thereby creating a potential addiction in patients. If the present trend of administration of sedatives continues there will come a time when they will have to be classified exactly as narcotics and dispensed accordingly.

—J. J. Lightbody, M.D., in the *Detroit Medical News*.

### BOOKS RECEIVED

*Cornell Conferences on Therapy, Volume I.* Harry M. Gold, M.D., Managing Editor. Published by the Macmillan Company, 60 Fifth Avenue, New York, New York. 322 pages. Price \$3.25.

*Journal of the History of Medicine and Allied Sciences*, Volume I, Number 1. Published quarterly by Henry Schuman, 20 East 70th Street, New York 21, New York. Price for single copy, \$2.50; annual subscription, \$7.50.

*Modern Management in Clinical Medicine.* By Frederick K. Albrecht, M.D. Published by Williams and Wilkins Company, Mount Royal and Guilford Avenues, Baltimore 2, Maryland. 1238 pages. Prices \$10.

*Physiotherapy.* By Thomas F. Hennessey, M.D., Dean and Director, Massachusetts School of Physiotherapy, Boston. Published by Bellman Publishing Company, Inc., 6 Park Street, Boston 8, Massachusetts. 23 pages. Price 75 cents.

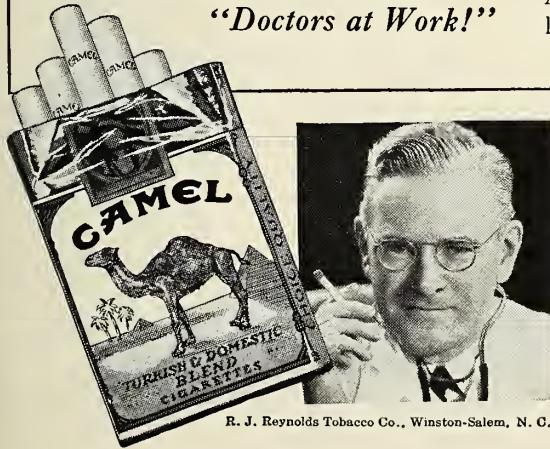
*Synopsis of Physiology.* By Rolland J. Main, Ph.D. Published by the C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri. 341 pages. Price \$3.50.

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### KANSAS MEDICAL ASSISTANTS' SOCIETY

The annual meeting of the Kansas Medical Assistants' Society was held at the Allis hotel, Wichita, on Sunday and Monday, April 21 and 22, with an attendance of 150. Members of the Sedgwick county group served as hostesses and spared no effort in making the occasion profitable and enjoyable for all.

The formal program, as published in the last issue of the Journal, was given on Sunday afternoon and evening and Monday morning. The luncheon session on Monday was called to order by the president, Zura Crockett, Wichita, and a short program preceded the business session. Mr. Hobert C. Brady, Wichita, addressed the group and vocalists from the St. Francis Training School, Wichita, presented several numbers.

The first important item of business was discussion of the proposed changes in the constitution and by-laws of the state organization. All of the amendments, as printed in the February 1946 issue of the Journal, were unanimously approved.

The matter of an official pin for members of the society was discussed and two designs were presented for consideration. One design was chosen by ballot, and the initial order for pins was taken. Members who were not present at the meeting may secure information on the pins from the chairman of the committee, Irene Miller, care of W. B. Granger, M.D., Gazette Building, Emporia, Kansas.

The meeting was concluded with the election and installation of the following officers: president, Marjorie Euler, Topeka; president-elect, Carmen Kline, Kansas City;

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and textbooks.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

**THE UNIVERSITY OF KANSAS  
SCHOOL OF MEDICINE**

vice president, Margaret O'Rorke, Dodge City; secretary, Irene Jermaine, Seneca; treasurer, Della Dunagan, Douglass; corresponding secretary, Pauline Farrell, Topeka. The council includes Mildred McClure, Kansas City; Irene Miller, Emporia; Lela Doile, Wichita; Birdie Stehno, Ellsworth; Lois Clapper, Dodge City.

### Retiring President's Message

As retiring president of the Kansas Medical Assistants' Society, I wish to take this opportunity to thank each and every member of our organization for the co-operation they have given me in the past two years, during my term as president. It was with your help that we maintained more than a normal membership and that we kept our organization together. Thank you for giving me the privilege of serving you.

These years have been two of the most enjoyable of my life and I shall always cherish them. It has been a pleasure to work with all the girls. They are the type of individuals who, when called upon to undertake a job, see that it is well done, and I am proud to be identified with such an organization—proud that I have had a small part in its success.

Sincerely,

Zura Crockett.

\* \* \*

### President's Message

Inasmuch as it is impossible for me to chat with each of you personally, I am happy to have this opportunity to send greetings by way of the Journal of the Kansas Medical Society.

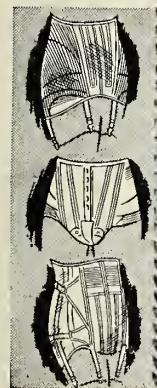
The theme I have selected for 1946-47 is "Harmony" and now that most of our doctors are at home again we will have more time to plan for "Peace and Harmony" as well as for advancement in our own society. As your president I would be most happy to hear from any of you who have suggestions or ideas so that I can work with the executive board to carry out as many requests as possible. I sincerely believe that

"Coming together is a beginning  
Thinking together is unity  
Keeping together is progress  
Working together is success."

Sincerely yours,

Marjorie Euler.

Every man owes some of his time to the upbuilding of the profession to which he belongs.—Theodore Roosevelt.



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## AUXILIARY

### President's Message

Memories of the good cheer and keen interest evidenced in our well attended convention give us fresh inspiration and renewed confidence in forging ahead toward the realization of our goal in going FORWARD this year.

For the benefit of those who did not have the opportunity to attend our annual meeting, and at the risk of repetition for those who were there, I would like to summarize briefly our thoughts, instructions and ambitions for the coming year.

We would like to ask each member to appoint herself a committee of one to study any national or state legislative medical problems—study them so thoroughly that she is able to discuss them intelligently. We further feel that we, as Auxiliary members, should accept offices in women's lay groups when offered us, or at least gain membership in these organizations. In that way we are on the ground floor should a question come up regarding medical legislation, the practice of medicine in general or our doctors. We have the unique opportunity as a member of that lay club to give correct and authentic information, thereby rendering a valuable service to the medical society.

Mrs. Biermann, Hygeia chairman, especially requested that all county Hygeia chairmen get in touch NOW (before school closes) with your P.T.A. president so she can have Hygeia subscription included in next year's budget.

A MUST for all members, particularly county presidents and all board members: National Bulletin, our official textbook.

If the public relations chairman of each county could list in her annual report nothing else but a public relations tea having been given, she would have a report well worth listening to.

We hope for gains and strides in membership—we welcome new county Auxiliaries—but we are especially interested in retaining the ones we have. Let all units elect a group of officers and be active again. Remember: friendliness and cooperation among our members will pay dividends in a harvest of stimulated interest in our meetings, increased membership and a wholehearted response to our objectives.

Mrs. Henry Lewis Regier.

### Brief Highlights of the Convention

The Auxiliary to the Sedgwick County Medical Society, as usual, was "tops" in the role of hostess and organizer. Many thanks are due Mrs. Tippin, president, and Mrs. Rombold, general chairman of convention arrangements, and their many assistants for the time and effort expended in perfecting details and arrangements.

The dinner on Tuesday night honoring members at large, the luncheon on Wednesday for the state officers and special guests, the public relations tea, the banquet that night, the breakfast on Thursday morning and the post-board luncheon on the same day—all will be remembered as outstanding events.

The messages from Dr. W. M. Mills, president of the Kansas Medical Society, and from Dr. C. Omer West, chairman of the Advisory Committee, will be an incentive to us in our endeavors to be an asset, not a liability, to them.

Our convention was honored to have in attendance at its meetings Mrs. Eben J. Carey, past president of the Woman's Auxiliary to the American Medical Association,

and Mrs. Luther Kice, national legislation chairman of that organization, who was the featured speaker at the public relations tea, having as her topic, "Socialized Medicine."

### New Officers

President.....	Mrs. Henry Lewis Regier, Kansas City
President-elect.....	Mrs. Floyd C. Beelman, Topeka
First Vice President.....	Mrs. Clyde D. Blake, Hays
Second Vice President.....	Mrs. Charles M. Jenney, Salina
Recording Secretary.....	Mrs. John A. Billingsley, Kansas City
Treasurer.....	Mrs. Charles H. Miller, Parsons
Corresponding Secretary.....	Mrs. H. R. Hodson, Wichita

### Chairmen

Archives and History.....	Mrs. Gerald C. Unrein, Hays
Exhibits.....	Mrs. M. A. Brawley, Frankfort
Legislation.....	Mrs. Donald N. Medearis, Kansas City
Hygeia.....	Mrs. W. J. Biermann, Wichita
Organization.....	Mrs. Hugh Hope, Hunter
Program.....	Mrs. Jack Dysart, Sterling
Press and Publicity.....	Mrs. R. E. Pfuetze, Topeka
Public Relations.....	Mrs. Charles Rombold, Wichita
Post War Planning.....	Mrs. E. R. Millis, Kansas City
Parliamentarian.....	Mrs. C. B. VanHorn, Topeka
Nomination.....	Mrs. Hugh Hope, Hunter
National Bulletin.....	Mrs. Leo J. Schaefer, Salina
Resolutions.....	Mrs. A. C. Flack, Fredonia
Revisions.....	Mrs. J. R. Campbell, Pratt

### Thanks to Our Retiring President

The following resolution was adopted at the general session of the convention "WHEREAS, Our president, Mrs. Hugh Hope, has served without the help and inspiration of a national convention and took office with little fanfare and at a time when the world has passed from war to peace and is exhausted after its labors,

"RESOLVED, We commend her for her splendid leadership, her constructive program, her understanding that the work of our auxiliaries was necessarily curtailed, and

"WHEREAS, Our president, Mrs. Hope, has through the years done outstanding work in legislation and has especially stressed this phase of Auxiliary activity this year and has urged our state to cooperate with the program outlined by our national legislation chairman, Mrs. Luther Kice,

"BE IT RESOLVED, That we continue to encourage and support the program to defeat the regimentation of medicine in America and that we promote all forms of legislation which will insure better health of our State and Union."

### Meeting in San Francisco

The 23rd annual meeting of the Woman's Auxiliary to the American Medical Association will be held in San Francisco, July 1 to 4, 1946, with headquarters at the Hotel Fairmont. A tea is planned for Sunday afternoon, June 30, to which all members of the Auxiliary are cordially invited.

Since hotels will be crowded, it may be necessary for those members who are attending the meeting alone to share a room with another member. Reservations may be made through Mrs. R. H. Hilton, c/o Housing Committee, Room 200, Civic Auditorium, San Francisco. Members are asked to include dates of arrival and departure with their requests.

The complete program of the meeting will appear in the May issue of the Bulletin.

***THE JOURNAL***  
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***KANSAS MEDICAL SOCIETY***

*Owned and Published by The Kansas Medical Society*

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Volume XLVII

JUNE, 1946

Number 6

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**THROMBOPHLEBITIS MIGRANS**

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The purpose of this paper is to report six cases of thrombophlebitis migrans (or idiopathic thrombophlebitis) seen in this hospital and to review some of the literature on this disease.

*Patient No. I.* The first patient (B.R. 83-48) was a 61-year-old white female first seen here in October 1924, at which time she complained of pain and swelling over the left side of her neck, the left shoulder and the left arm. History revealed that six days prior to her admission she became ill with swelling and pain over the left side of her neck. The pain then extended out over the left shoulder onto the left arm, and the entire left arm became swollen. There was increased temperature locally and marked tenderness over the veins of the left arm. Physical examination was negative except for the tender, cordlike thrombosed veins over the left arm and the left side of the neck. Thrombosed veins were also present over the lower portion of both legs and the feet. The latter were remnants of a previous attack of thrombophlebitis. This patient remained in the hospital one month, during which time she developed a thrombophlebitis of the superficial veins of the right thigh. She slowly recovered from the attack and was entirely well on dismissal. During her hospital stay she ran a low grade fever. The blood count was normal. Two weeks after dismissal she died rather suddenly of what was thought to be a cerebral embolism.

*Patient No. II.* This 32-year-old white female (O.K. 83-103) was first seen in this hospital in January 1925, at which time she complained of pain and swelling in her left leg, soreness in her right leg, pain over her heart, and dizziness. Physical examination revealed a segmented thrombophlebitis of the superficial veins of both legs. Nothing else of importance was noted on this examination. During this patient's stay in the hospital she had very little fever and a normal white blood count. A biopsy

was done on the thrombosed veins of her leg. This showed an organized venous thrombus. For the next three years she continued to have recurrent attacks of migrating thrombophlebitis of the veins of her legs. In 1927 she was readmitted to this hospital and a tonsilectomy was done because of chronic tonsilitis. She again complained of pain over her heart; an electrocardiogram was taken and showed an auricular tachycardia. There was no other evidence of myocardial or coronary vascular disease. The tonsilectomy failed to relieve the attacks of thrombophlebitis. In April 1928, a cholecystectomy was done because of symptoms of chronic gall bladder disease. The gall bladder showed evidence of an old inflammatory process. This produced no relief of phlebitic symptoms. In October 1928, the patient became suddenly ill with symptoms of acute intestinal obstruction; at operation a mesenteric thrombosis was found. The patient succumbed to this complication. Autopsy report is not available.

*Patient No. III.* (J.G. 63849) This was a 25-year-old white male who was admitted to this hospital in November 1936 complaining of recurrent attacks of abdominal pain accompanied by severe nausea and vomiting and general malaise. More recently he had noticed progressive enlargement of his abdomen. The history revealed that this man had always been in excellent health until February 1936 when he became ill quite suddenly with severe pain in the right side of his abdomen, general malaise, nausea and vomiting. This illness lasted three days, following which he again felt quite well. He then had recurrent attacks all very similar to the first at intervals of two to three weeks until his admission to this hospital. At the time of his third attack, an appendectomy was done. We have no record of the operative findings. The post-operative course was uneventful. In October 1936, during an acute attack, he noticed the onset of progressive abdominal enlargement. He also noticed some yellowish dis-

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coloration of his skin during the last few attacks prior to his admission.

Physical examination revealed a poorly nourished white male with a slight icteric color and marked ascites. High grade oral sepsis was present. Tonsils were absent. There was distention of the veins of the upper abdomen. The liver was enlarged three fingers below the costal margin.

The laboratory examination showed a red blood count of 2,700,000, hemoglobin 61 per cent, and a white blood count of 7,800. The urine was negative except for a trace of albumin. The icteric index was eight units, the serology negative, liver function tests were normal. The ascitic fluid was straw-colored, specific gravity 1.012, and the routine cultures and guinea pig inoculations were negative.

The patient was treated conservatively for a time. He made no improvement, however, hence a modified Talma-Morrison omentopexy was done in an attempt to establish collateral venous circulation. Biopsys taken of the liver and peritoneum at operation showed chronic periportal hepatitis and chronic peritonitis.

Repeated paracenteses were done at one to two week intervals; each time seven to eight liters of fluid were removed. On about the 70th hospital day he developed a necrotizing staphylococcus aureus infection in one of the trochar wounds. He died a few days later. Fever was present throughout most of his hospital course.

Autopsy showed acute thrombophlebitis of the inferior mesenteric vein and its radicles, thrombophlebitis of the hepatic veins, portal emboli, infarction of the liver and lungs, chronic periportal hepatitis, subacute glomerulonephritis, acute hemorrhagic cellulitis of the mesentery and the abdominal wall.

*Patient No. IV.* (R.B. 66650) This was a 27-year-old white male who entered this hospital in May 1937 complaining of recurrent attacks of severe abdominal pain. The history revealed that four months prior to admission to this hospital he became acutely ill at 4:00 a.m. with diffuse abdominal pain, nausea, vomiting, watery diarrhea and a fever of 104 degrees. Two days later he developed pain in his right elbow followed the same day by a migrating thrombophlebitis of the right arm. There was redness, swelling and exquisite tenderness over the superficial veins of the arm. He recovered from this illness in about one month. Two weeks later he became acutely ill again with the same symptoms and two days later he developed a migrating thrombophlebitis of the right leg. He recovered from this attack in three to four weeks.

One day prior to his admission here, he had a return of his abdominal symptoms and on the day of admission he developed a migratory thrombo-

phlebitis of the left leg. This began with pain and tenderness in the groin and then spread down the superficial venous channels, and the deep veins of the leg.

Physical examination showed cord-like thrombosed veins over the right arm and in the right popliteal space. There were tender, red, swollen superficial veins over the right leg with tenderness over the veins in the groin. The veins of the upper abdominal wall were dilated but not thrombosed. The oral hygiene was good. Heart and lungs were negative. The liver was enlarged slightly below the costal margin.

Laboratory findings were normal except for a four plus Wasserman and Kahn. The temperature on admission was 102 degrees; it remained elevated for several days, then returned to normal and remained normal.

The hospital course was uneventful except that he developed a thrombophlebitis in the dilated veins over the upper abdomen. This occurred on the eighth hospital day. The lesions were all healed on dismissal. Communications with this patient several months later revealed he had experienced no more trouble with this disease.

*Patient No. V.* (E.B. 92956) This was a 43-year-old obese white female who entered this hospital in September, 1941, with the chief complaints of a sore, red left leg, a chronic cough and high blood pressure. The history revealed that the patient had a rather sudden onset of stinging pain in the left lower leg several days prior to admission. This was followed by redness and some swelling over the involved area. The inflammatory process then extended up the left saphenous vein. The attack was accompanied by some fever, pain in the chest, and cough. The past history revealed that ten years prior to admission this patient suffered an attack of migratory thrombophlebitis of both legs lasting six weeks, and three years prior to admission she had an attack of thrombophlebitis of the left leg. She also had two full-term normal deliveries, three miscarriages, one major abdominal operation, and pneumonia five times.

Physical examination showed an obese white female with high grade oral sepsis, blood pressure of 210/140, pulse 96, temperature 100 degrees, rales in both lung bases and tenderness in the left upper abdomen. There was extensive thrombophlebitis of the superficial veins of both thighs. These were red, swollen and extremely tender; they were cord-like to palpation. There was one plus pitting edema of both legs.

Laboratory work was entirely negative. The Wasserman was negative. X-ray of the chest showed moderate peribronchial infiltration. The blood sedi-

mentation rate was 15 millimeters by the Cutler method. The hospital course was uneventful until the eighteenth hospital day when she developed pain in the left upper abdomen accompanied by watery diarrhea and a leucocytosis of 13,000. There was no nausea, vomiting or fever. The following day, marked thrombophlebitis of the veins of the left upper abdominal wall was present. Three days later a similar phlebitis developed in the right upper quadrant of the abdomen. After this she got along quite well except for repeated attacks of pain in her chest. Nothing definite could be made out of this pain. The phlebitis healed and she had had no more trouble when she was seen again several months later.

**Patient No. VI.** (J.R. 124992) This was a 33-year-old Jewish man who entered the hospital in September, 1945, complaining of recurrent attacks of sharp pain in his right groin and leg accompanied by redness and tenderness over the lower half of the leg. This first attack occurred three and a half years ago. There was no preceding infection, trauma or other known precipitating cause. Since the onset he has had five similar attacks. They have always been confined to the right leg. The attacks have usually lasted from three to six weeks, during which time the patient was completely incapacitated as far as working was concerned. The attacks were accompanied by general malaise and low grade fever.

The past history and family history were non-contributory. He is a periodic smoker and believes that one attack came on shortly after a debauch of smoking.

The physical examination was negative except for the lower half of the right leg. Here there were numerous disseminated areas of thrombosis of the superficial veins. There was an erythema surrounding the thrombosed veins, and there was marked tenderness and swelling over these areas. There was some erythema and tenderness over the saphenous vein in the thigh. Moderate inguinal lymphadenopathy was present, and a low grade fever was present on admission. There was no evidence of arterial disease.

Laboratory work showed a normal blood count, negative serology, a few pus cells in the urine. Blood culture was negative, urine culture showed a few colonies of *staphylococcus aureus*. Blood agglutinations were negative. Blood clotting time was eight minutes, bleeding time one and one-half minutes, platelet count 150,000. Prostatic fluid cultures were negative. The sedimentation rate was 20 mm. in one hour by the Cutler method. Dental films showed the upper left cuspid lying obliquely unerupted in the alveolar process.

The patient has had various forms of therapy. One

and a half years ago a saphenous ligation was done. On another occasion leeches were used. He has had foreign protein injections and also penicillin has been given on the last two attacks. The patient felt that recovery occurred more rapidly after the use of penicillin than with any previous form of therapy.

*General Discussion of the Disease.* Thrombophlebitis migrans may be defined as an acute inflammatory disease of unknown etiology usually occurring in otherwise healthy adults and characterized by recurrent attacks of thrombophlebitis of short, disseminated segments of the small and medium-sized veins of the extremities and the body wall, or by single attacks of thrombophlebitis of the larger veins of the extremities and the body viscera. Fever, leucocytosis and the embolic phenomenon may or may not be present. Pain, redness and swelling over the affected vessels are uniformly present.

This disease is not new. Reports appeared in the literature as far back as 1845 when Jadioux reported a case in a 20-year-old healthy man. In 1864 Fremy reported a case in a man of 56. Sir James Paget aptly described the disease in 1866 when he wrote of a type of thrombophlebitis not associated with trauma, exhaustion, infectious disease, local inflammation, pyemia, puerperium or varicosity. He thought the disease occurred only in people who had gout or who had a gouty inheritance.

In 1894 Daguillon wrote on the disease. He reported five cases and reviewed seven others. He believed the disease was the result of a diathetic or arthritic—non-gouty—influence.

Briggs in 1905 stated that the disease should be called "idiopathic recurrent thrombophlebitis" and he largely exploded Paget's and Daguillon's views on the arthritic origin of the disease. He pointed out that this disease was unique in that it usually occurred in otherwise normal healthy adults, that is, was a separate process from that which occurred in people suffering from tuberculosis, anemia, pyemia and other infections.

In 1909 Buerger emphasized the association of recurrent thrombophlebitis of the veins of the arms and legs with thrombo-angiitis obliterans. He further pointed out the necessity of examining the arteries in patients with recurrent thrombophlebitis for any evidence of disease.

Many other investigators have reported on this disease, including Neisser, Schwarz, Herrick, Ryle, Moorhead and Abrahamson, Barker and others.

The etiology of thrombophlebitis migrans is unknown. Numerous theories have been advanced. Among them are Paget's uricogenic theory, Daguillon's arthritic diathesis, Brigg's phlebosclerosis, Herrick's toxin theory, Owen's influenzal theory, the Ryle, Kletz and Hartfall and Armitage focal infec-

tion theory and Harkavy's tobacco theory. Of these, the focal infection theory seems to be the most plausible. Of our patients, three had definite evidence of focal infection, two had high grade dental caries and pyorrhea, and one had chronic tonsilitis and chronic cholecystitis. In the last patient there was an unerupted impacted tooth present; these are frequently found to be foci of infection.

In the 114 cases reviewed (six of which are ours), there was no mention made as to whether focal infection was present or not in 25, in 23 it was stated not to be present. In 67, or 74 per cent, of the 89 known cases, focal infection was present. This was most commonly found in the teeth and gums, the tonsils, the prostate gland, the cervix, chronic otitis media, and the paranasal sinuses. In the few patients in whom blood cultures or cultures from the gums, prostate or cervix were made, the hemolytic streptococci were most frequently found. In two instances streptococcus viridans was found. The number of cases in which cultures were made is too small for statistical value.

The age at which thrombophlebitis migrans appears varies from 10½ years to 69 years. Most cases, however, occur between the ages of 25 to 50 with an average age of 40 years. Men are affected more commonly than women, in a ratio of about three to one. There is no predilection of the disease for any race. The Negro seems to be spared, at least I have found no reports of the disease occurring in the colored race.

The site of the disease is most commonly the superficial veins of the extremities and the body wall. In the 114 cases reviewed, 50 were confined solely to these locations. Of these, by far the majority occurred in the extremities, the lower extremities being affected more frequently than the upper extremities. In ten patients there was involvement of both the superficial and deep veins of the extremities. In 39 patients the lesions were primarily concerned with the deep veins of the extremities and veins of the neck. In nine patients there was involvement of the veins of visceral organs. The mesenteric vessels were involved in five patients, the heart in two, and the brain in two. In 23 patients there was involvement of the lungs. Previous to the time of Barker, when pulmonary complications occurred, they were attributed to thrombophlebitis of the pulmonary veins. However, as Barker pointed out, when pulmonary complications occur it is more likely that embolism has occurred from venous thrombosis elsewhere than that there was actual thrombophlebitis of the pulmonary veins. Only careful post-mortem studies can answer this question. Pulmonary complications occur more commonly following thrombophlebitis of the superficial veins than fol-

lowing disease of the larger veins. When it does occur it usually occurs early in the disease.

Biopsies have been made on many occasions, both for culture and pathological section. Cultures have been uniformly negative. Pathological sections show occlusion of the lumena of the veins with well organized connective tissue and fibroblasts in which there may be a few erythrocytes, lymphocytes and neutrophiles. Usually there are a few clefts or canals present inside the mass of occluding tissue; these are lined by endothelium. The internal elastic membrane is often thickened and partially disrupted. The medial coat and adventitia of the venous wall are usually quite well intact; occasionally they are invaded by fibrous tissue and a few lymphocytes and leucocytes.

The pathogenesis of this disease is indeed not clear. To discuss it brings up the old question of primary phlebitis and periphlebitis versus primary intravascular thrombosis with a secondary inflammatory reaction. The weight of evidence is in favor of the former. It is believed by many that some toxic factor which may have a special affinity for venous tissue injures the endothelium of the vein resulting in an inflammatory reaction. Further evidence in favor of this theory is that cases have been reported in which no thrombosis occurred—there was only the local inflammatory reaction and when the acute phase of the disease was over the venous channels were entirely normal.

Laboratory work has yielded little additional information except that already given. In eleven of Barker's cases, plasma coagulability tests were done. In three of these there was a definite increase in coagulability of the plasma; in eight patients it was normal. In four other patients, blood coagulation times were done, and the coagulation time was reported as follows: Normal in one, eight minutes in the second, three and one-half minutes in the third, and in the fourth, three minutes on one occasion and one and one-half minutes two weeks later. Blood cultures are reported in eight patients; they were negative in all but one, in which *B. alkaligenes* was cultured.

The clinical picture of the disease depends, of course, on the location or site of the venous inflammatory process. If this is in the extremities or body wall, there may be only pain, swelling, redness and tenderness over the short segments of cord-like thrombosed veins. This may or may not be accompanied by low grade fever and general malaise. If the lesion occurs in the saphenous or femoral vein, there will be swelling of the entire limb with diffuse pain, redness and tenderness over the vein involved. If the lesion occurs in the mesentery, the severe symptoms of intestinal obstruction with me-

lena, high fever, nausea, vomiting and great prostration may ensue. In one of our patients in whom it was felt that the veins of the heart were involved, an auricular tachycardia developed. In a case of suspected cardiac involvement reported by Hirschorn, Lisa and Goldstein, marked heart failure developed and the electrocardiogram showed a minor conduction defect and a paroxysmal ventricular tachycardia. The patient in whom the cerebral vessels were involved had recurrent attacks of thrombophlebitis migrans of the veins of the extremities and then began having periodic attacks of syncope and later developed choked discs. A craniotomy was done and a subdural hematoma was evacuated. It was noted at operation that the vessels of the meninges showed rather marked thrombophlebitis. This undoubtedly represents a case of thrombophlebitis migrans of the cerebral vessels.

The acute attack of this disease usually lasts from two to six weeks, during which time the patient is more or less incapacitated. Following this the patient may have recurrent attacks of a similar nature at rather frequent intervals or he may go as long as seven to ten years, as one of ours did, without a recurrent attack. On the other hand, he may never have any more attacks. Patients showing involvement of the superficial veins show a much greater tendency to have recurrences than those who have involvement of the deep veins. The disease is thought to be self limited and it is felt that in most cases it finally disappears without causing much permanent damage to the patient.

The mortality rate in our patients was 50 per cent. This is much higher than the general mortality rate. Of the 114 cases reviewed, the mortality rate was eight per cent. Three of the patients died of mesenteric thrombosis, five of a pulmonary embolism, and one of cardiac failure.

Death from the disease is, of course, not the only serious complication. Chronic edema of one or both of the extremities is not rare following thrombophlebitis of the femoral veins. Persistent chronic varicose ulcers are common. One of our patients developed ascites from partial obstruction, and another reported in the literature developed gangrene of the left breast.

The differential diagnosis is usually not difficult.

From almost the beginning of comprehension concerning the magnitude of the role played by allergy in human ailments it has been apparent that no method for its control could ever be satisfactory short of one which bi-passed the laborious and impossible sleuthing processes necessary to seek out and then deal with separately, the endless varieties of allergens to which any patient might be sensitive.

Buerger's disease or thrombo-angiitis obliterans offers the only real problem of differentiation. Some few cases of Buerger's disease are reported to begin with recurrent attacks of phlebitis. Usually, however, there is a fairly typical history obtainable in Buerger's disease and, before the disease has gone far, evidence of arterial disease can be found.

As to therapy, we can only say that removal of foci of infection should be the first objective. Vaccines, dicumerol, sulfonamides and penicillin have been used with questionable results. Venous ligation does not appear to be of any great value. A saphenous ligation was done in patient No. VI and proved of no benefit, unless it did serve to protect him from pulmonary emboli. This patient received penicillin during his last two attacks of thrombophlebitis. He felt that he got definite benefit from this medication, in that the acute phase subsided much more rapidly. Workers who have used dicumerol feel that it is a drug of definite value in this disease.

In conclusion we may say that, in general, thrombophlebitis migrans is a disease of young and middle-aged men, that it is primarily a disease of the small and medium-sized veins, that it shows a marked tendency to recur and involves short disseminated segments of these veins.

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Such a development could come from either of two directions—it could provide a universal allergen, desensitization to which would eliminate all sensitivities, or it could recognize and correct a possible defect in the tissues of allergic individuals whereby they had been enabled to become sensitized in the first place.—W. Ray Shannon, M.D., in Minnesota Medicine, December, 1945.

## CONSERVATION OF RESIDUAL HEARING\*

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Never before in our history has there been so much attention directed to the conservation of hearing. Selective Service experience and that of the military services brought out in bold relief that the numbers in the misfit group incontrovertibly upset the assumption that we are a healthy nation. Four out of every thousand 18 to 19 year olds were found unfit by Selective Service because of ear disease or defective hearing. This figure seems rather conservative in the light of experience in the Navy where we found that about 40 per cent of the deafened Navy, Coast Guard and Marine personnel had their aural defects prior to their entrance into the service. Moreover, a liberal attitude on the part of the Medical Department of the Navy gave the benefit of the doubt to many who were credited with a line of duty disability. We must acknowledge the vision displayed by the Army and Navy in putting into actual operation programs which civilian groups have long sought to organize. The most outstanding contribution of otology to the World War II was that which concerned aural rehabilitation.

The urgent and essential need of adequate treatment for aural disabilities indicates that the field is extensive enough to warrant concerted action at considerable expense of time and energy by all interested groups. There is sufficient foundation of institutional experience with the treatment of large numbers of hard of hearing persons to enable such groups to set up definite procedures that are workable.

Service experience with the reconditioning and reconstitution of adult hard of hearing persons, as distinguished from the congenitally deaf, furnishes a pattern and a methodology that can be translated into civilian needs under the leadership of American otologists.

Rehabilitation of the hard of hearing is a modern advance and can be successfully achieved through a definite and well-organized program. Such a program has been conducted in the Army and Navy and the pattern may well be followed in civilian life. There are specific requirements, not the least important of which is a trained personnel. There are many millions of deafened and partially deafened persons in the United States (an estimated 16 per cent), who could avail themselves of constructive treatment and training which experience has demon-

strated as being highly beneficial from a rehabilitative standpoint.

For the deafened, rehabilitation implies a more or less complete readjustment of life. It embraces the measures which refit the hard of hearing persons for a normal conduct in daily activities. These measures are unrestricted as they may be both medical and non-medical, but in a more narrow sense are confined to a program of physico-psycho-social therapy.

**PERSONNEL**—The professional fields essential to a program of aural rehabilitation include otology, psychology, speech reading, speech correction, auditory training, audiometry and acoustics. Collateral duties are carried out by a group composed of occupational therapists, specialists in educational services and prevocational training, physical training instructors and medico-social workers. Members of the staff of an aural clinic should be equipped by background and training to perform several different kinds of tasks in the rehabilitative process. Only in the larger institutions is specialization for personnel desirable.

The size and efficiency of a staff of technicians and teachers in a program of hearing rehabilitation is conditioned by the character and extent of the physical space and equipment. Although classes in speech reading and auditory training can be expanded within reason, the technical operations—quantification of hearing loss, selection and fitting of hearing aids—limit the number of patients that can be handled adequately within any training period.

**STANDARDS OF ADMISSION**—With but few exceptions unilateral deafness is insufficient to warrant admission to the retraining program. In general, persons are admitted for hearing rehabilitation who have a loss within the frequency range of conversation of at least 30 decibels in the better ear. This has been demonstrated as the level of hearing loss at which the patient himself notices a desirability, a lesser loss is not always subjectively significant.

**PHILOSOPHY AND GENERAL APPROACH**—The fundamental idea of a program of aural rehabilitation is its centralization in the patient's personality. The task at hand is complex—the psycho-physical reconditioning of a person to the point where he is a healthfully functioning human being. The goal is the restitution of the total person. A man is taught speech-reading, fitted with a hearing aid and trained to use it. He is, moreover, educated in the problems of his handicap and taught how to meet those prob-

\* Presented before the 87th annual session of the Kansas Medical Society, Wichita, Kansas, April 23, 1946.

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lems intelligently. Essentially, as far as the psychology of deafness is concerned, a proper functioning speech and hearing program is an individualized course of mental hygiene; it is aimed to help a person gain and maintain self-confidence, to give him the foundations of self-support by developing in him greater objectivity regarding his disability and its effect upon his life.

There is little doubt concerning the fact that what interferes with a person's ability to communicate affects the most human part of us. Whatever else he is, man is a social person whose every detail of daily thought and action is intimately connected with his habits of communication. Speaking and hearing, the two elements of the communicative process, cannot logically be separated; it is an interrelated process. Any serious impairment in either of these elements of communication results in a breakdown of the machinery of human relations. The rehabilitee must learn new ways of getting along in a world that is dependent on communication. If he wears a hearing aid, he must learn to *think and act like a person who wears a hearing aid*, not like a person who is perfectly normal but cannot hear well.

The person who is deprived of the free use of language tends to turn inward, to become depressed, unobjective, negative in his attitudes toward himself and fellows. Herein fits the portion of the program that is the work of the clinical psychologist, the psychometrist, the educational specialist, the pre-vocational counselor, the medico-social worker. What can be accomplished depends on who the patient *is*—who does not hear, what he *has done* in the past, what he wants *to be* and is capable of *doing* in the future.

**GROUP THERAPY**—The contribution of group therapy to the problems of aural rehabilitation is essentially a re-educational approach to the task at hand and occupies an important place in the reconstitution of the *total person*. The rehabilitees may be brought together twice a week or oftener for an hour or more to hear generalized discussions of their problems. Several talks should be specifically concerned with the psychology of hearing deficits and mental hygiene. A number of lectures should be delivered by otologists who will give clear explanation of the hearing mechanism and its ailments.

Other lectures deal specifically with the physical attributes of the hearing aid, and with observations on its care and use. A final talk is to be devoted to a careful discussion of typical vocational problems to be met by the person who wears a hearing aid. The patients should be given ample opportunity to ask questions and to satisfy their own particular problems of adjustment.

**THE RE-EDUCATIONAL PROGRAM**—A re-educational program for aural rehabilitees should have three elements—*speech reading, auditory training, and speech training*. The degree, type and duration of hearing loss and the prognosis for each patient should control the emphasis placed upon each of these elements in a re-training program.

A person with a profound hearing loss will inevitably be heavily dependent upon speech reading and will require more skill than the person with a medium loss whose hearing aid gives him fairly adequate sound perception. The patient with a slight loss needs relatively little work with residual hearing, once he has learned to use his aid efficiently; the person with a moderately heavy loss requires a complete re-education in the identification and interpretation of sound stimuli under a variety of circumstances. Patients should receive speech training and special remedial attention according to whatever individual defects or disorders of articulation require treatment.

Every person who can profit from the use of a hearing aid should wear one as soon as possible. He gains confidence from his ability to hear again; he can participate more actively in social life. Even patients with a heavy hearing loss profit greatly from the amplification furnished by an aid. They can usually distinguish some speech sounds and are thus helped to fill in the visual gaps of speech reading, and, equally important, receive sound cues which stimulate their attention to activities around them.

An introduction to English phonetics furnishes a working foundation for the retraining task. This is a simple study of speech articulation which enables the patient to determine where, and to some extent, how, sounds are made.

**SPEECH READING**—The Jena method invites a close correlation among speech, speech reading and auditory training of residual hearing, thus utilizing all the rehabilitee's experience in communication. This system is built upon the thesis that speech has various forms—the *audible*, the *visible* and the *kinesthetic*, or "feeling" form. Of these, the kinesthetic is the only one that is complete for everybody under all circumstances; a hearing loss affects audibility, and only about a third of the speech sounds of English are visible. For this reason, the Jena method emphasizes the "feeling" of speech together with what audible and visible cues are available; patients are taught to feel, hear and see simultaneously. They are taught to recognize some of the other cues that are associated with a typical speech situation—gestures, facial expression, objects handled or referred to, the place and the personality of the speaker. All these elements of communication serve to supplement the experience of seeing, hearing and feeling.

That is to say that the rehabilitee is taught not *lip* reading but *speech* reading. He is trained to become aware of the movements of his own speech mechanism. The average person develops this habit of reading speech with considerable ease. The training is given in groups or classes and each group remains with an instructor for about one week, then is assigned to a new instructor. Thus, in the training period, a patient has experience with four different teachers. By the time he is ready for his final proficiency test—a requirement for his completion of the Rehabilitation Program—he has been exposed to a fair variety of problems in speech reading.

**AUDITORY TRAINING**—Auditory training is preferably carried on in conjunction with speech reading and entails practice in listening to amplified sound through both group and individual hearing aids in carefully controlled situations. The course in auditory training involves a complete re-education of the person's hearing habits. He is expected to master the changes and nuances of connected discourse, as far as this can be done. He is acquainted with his own hearing problems and with some of their solutions and learns to adapt himself to his own hearing aid. He should become aware, at least to some considerable extent, of his future, as "a person who wears a hearing aid."

**SPEECH TRAINING AND CORRECTION**—An introduction to the general principles of good speech and voice is complementary to the work in both speech reading and auditory training. Daily work with articulation drills in speech reading, as well as the work with sound discrimination in auditory training, sharpen the articulatory habits of the rehabilitees and help to bring about a general toning-up of their speech patterns. Patients should receive regular instruction in the fundamentals of breath control and in the development of effective pitch, rate, volume, resonance and quality.

The great majority of rehabilitees offers no significant evidence of speech deterioration; their hearing disability is so recent that it had not yet begun to undermine their normal habits of articulation and phonation. For them speech training is insurance against the future.

**AUDIOOMETRY AND THE FITTING OF HEARING AIDS**—Of the various tests and examinations which furnish evidence for an evaluation of the aural rehabilitee's special problems, those which actually determine the type of his hearing loss and establish the degree of loss in quantified terms are of primary importance. They furnish conclusively data to determine the usefulness of a hearing aid; or, if an aid is contraindicated, these tests suggest the pattern of retraining necessary for a patient.

For some time now the audiometer has been an

accepted standard instrument for measuring the acuity and range of hearing. Audiometric tests for the hard of hearing are best given in a sound-treated room and must be given by an experienced technician. A sound-proofed room is not always necessary. Competent audiology must, however, be conducted in a controlled situation. A capable audiometrist should be acquainted with three or four good techniques, and sufficiently familiar with them to vary the procedures with the patient. The record is the audiogram, a graphic representation of the patient's hearing loss. Supplemental to these tests is the one for speech reception. It is held that the test for speech reception is the most valuable single means for measuring a person's hearing perception.

The type of audiogram, the residual hearing in speech reception, the results of the otoscopic examination, history of ear noises (tinnitus), tuning fork tests, and other pertinent data, all contribute to the selection of the hearing aids to be tested for the rehabilitee. No fit is considered satisfactory unless the aid gives a minimum gain in speech reception of 30 decibels, (or brings the hearing into the normal range) and is comfortable from every aspect. The fit of the molded earpiece is important, for the efficiency of an aid may be dissipated by a poor fit. Fitting the aid is a highly individual process, and a final choice should be made only when the instrument satisfies the severest subjective and objective standards.

**HEARING AIDS**—There is no such thing at present as one hearing aid that is capable of all-around performance. Evidence of improved design in recent years leads to the hope that an ideal aid will become available before very long; when it is, some of the problems of aural rehabilitation will be automatically settled. The ideal instrument yet to be perfected would be an all-duty hearing aid embodying the following features:

1. A single transmitter (with as few varying models as possible) together with a variable tone-control which actually governs the tonal complex reaching the ear.
2. Incorporation of an adequate suppression of ambient noise beyond certain maximal sound-pressure levels, thus lending itself to a variety of maximal tolerance levels.
3. Frequency amplification extending over a range from 250 to 4,000 c.p.s. and containing a control to regulate amplification.
4. A combination battery pack sufficiently adjustable to be packaged with the transmitter or worn as a separate unit.
5. A standard receiver built to accommodate the maximal variables of the "perfect" transmitter.

6. Plastic-treated cords, which have been found to produce less of the disconcerting cord-noise.

**MEDICO-SOCIAL WORKERS**—In a program of aural rehabilitation medico-social workers are trained consultants. Their position is partly liaison, partly instructional and partly advisory. They should be thoroughly grounded in the problems of the hard of hearing. Their duties carry them into the fields of psychology, guidance, education, vocational training, arts-and-skills, hospital administration, social casework, and personality adjustments relating to medico-social problems.

**PROSPECTUS**—The necessary steps in the procedures of examination, evaluating and selecting hearing aids, retraining residual hearing with the use of an aid and developing skill in speech reading, are clear-cut. There are three types of establishments to serve the needs for aural rehabilitation, viz.,

1. *The University Medical Clinic*—The first of these is a hearing clinic in a university medical center. Such a clinic should consist of a complete rehabilitative organization, fully staffed and fully equipped to assume every responsibility that relates to problems of hearing disability, speech disorders, the conservation of hearing and the training of speech habits. Such an organization would encompass three associated aspects of rehabilitative work: (1) the treatment and retraining of the speech and hearing handicapped; (2) education, including the training function for professional personnel and the dissemination of public information in the field; and (3) research on every aspect of speech and hearing disorders and re-education.

A university medical center, preferably one directly associated with an otolaryngological department seems to lend itself best to this design. Facilities must be ample and personnel sufficiently specialized to produce good work and to conduct the rehabilitative process with thoroughness and dispatch. Such centers should assume leadership in training professional personnel and in disseminating to various state and community organizations the knowledge of methods and practices necessary to meet local problems and local needs. This knowledge must be drawn from the clinical experience of the university hearing center and extended through a responsible research program that is devoted to problems pertinent in the field.

2. *The Metropolitan Clinic*—A somewhat different type of clinic would be available in metropolitan areas. Here, it is assumed, efforts would be directed solely toward the rehabilitative task with no special provisions for public—educational and research projects. A feasible organization can readily be developed in conjunction with the major hos-

pitals in the area, the hearing clinics to be set up as special hospital services.

Envisioned in a city of a million population is a hospital-centered hearing clinic, sufficiently well equipped to provide all necessary rehabilitative services. An annual patient load of approximately 1,000 would require a minimal clinical staff of 10, including 2 otologists and 8 non-medical personnel. Our hypothetical city would need from three to five such clinics in order to furnish adequate service for the hard of hearing population. This, it is believed, is an entirely reasonable state of affairs. Such a clinic would furnish all necessary services for diagnosis and treatment, for evaluating, and fitting hearing aids, for training the patients' residual hearing with an aid, and for teaching the fundamentals of speech reading. It would be recommended that patients continue to develop skills in speech reading with private tutors, once the clinical service had supplied the groundwork. For all other rehabilitative services, the clinic would continue its service with follow-up consultations.

3. *The District Clinic*—A third type of establishment would be necessary to provide essential aural rehabilitation in rural districts. The precise nature of such a rural speech and hearing clinic is somewhat more difficult to outline than are the university and metropolitan centers. Municipal and county hospitals would seem to be feasible sites, and certain minimal requirements by way of equipment and personnel are apparent. Otological service might well be provided on an itinerant plan, as might the services of a qualified acoustic consultant. Other basic rehabilitative services, such as audiometry, fundamental auditory training and speech reading instruction, and educational-vocational consultation, should be at hand in the clinical center. In some districts college and university clinics could assume these responsibilities for hard of hearing persons in the section. In some states, services for the adequate measurement of hearing acuity have already been extended to rural sections; it would probably be necessary, however, to supplement these broad checks on handicaps with thorough retests for specific problems.

**SUMMARY**—Attention has been directed to the pattern set by the military in the reeducation of the adult hard of hearing. The therapy employed in this clinical service to the adult deafened is an amalgam of the best medical and non-medical practice that can be provided. The central task of aural rehabilitation is necessarily psycho-physico-social, and the variable aspects of the program serve cumulatively to build up a pattern of successful performance for the individual.

## DIPHTHERIA AND THE HEART\*

Mahlon H. Delp, Colonel, M.C., A.U.S.

and

Edmunds G. Dimond, 1st Lieutenant, M.C., A.U.S.

Although myocarditis has come to be the most common cause of death in diphtheria, and such cases are frequently reported, physicians still do not respect the gravity and frequency of this complication. The disease, with accurate clinical descriptions, has been recorded since the time of Celsus and Hippocrates but the possibility of cardiac involvement was not recognized until the middle of the 19th century. In 1842, Werner<sup>1</sup> definitely associated the pathological changes in the heart with collapse and death in diphtheria. Many conjectures concerning the basic pathology have resulted but close clinical observation and meticulous anatomico-pathological examination by such students as Warthin<sup>2</sup> and Councilman et al<sup>3</sup> established the complete picture of this serious complication on a firm footing. The work by Warthin, in itself a classic, concluded that the primary pathology was a toxic parenchymatous degeneration of the myocardium, most frequently of a hyaline nature, and if survival occurred was followed by reparative inflammation with muscle regeneration. He found no evidence indicating a unique affinity of the toxin for the conducting apparatus. In those cases with conduction system involvement, the same type of toxic necrosis was demonstrated as was present in the general myocardium.

With the additional aid afforded by the electrocardiogram, a definite relationship between pathology and physiology has been determined. Burkhardt, Eggleston, and Smith<sup>4</sup> recorded observations in seven cases of diphtheria, examined post-mortem, concluding there was rough correlation between the degree of disturbance in conductivity, as shown by the electrocardiogram, and microscopic changes in the myocardium. They added, however, that they could not correlate the electrocardiographic changes in a given case with specific demonstrable lesions of the conduction system, *per se*. Flemming and Kennedy<sup>5</sup> have reported one instance in which they were able to demonstrate focal inflammatory lesions within the bundle. Clinically this patient had a complete heart block.

In a five-year study, Hayne and Welford<sup>6</sup> saw 4,671 cases of diphtheria. Among these there was a case fatality rate of 11 per cent. Myocarditis was demonstrated as a complication in 496 instances or 10.6 per cent of the group. Sixty-two per cent of this last group came to autopsy and the cause of the

death was accounted for by the presence of a severe myocarditis. In the words of these authors, "The heart in each case was a pale grayish color, having the appearance of boiled meat."

Excellent studies of the electrocardiographic changes in diphtheria have been made<sup>4, 7, 8, 9, 10</sup>. We are presenting the case histories of three patients with diphtheria and their electrocardiograms because we were able to obtain an unusually complete series of tracings. We feel that further emphasis upon this dangerous complication of a serious disease is justified.

### CASE SUMMARIES

Case I. Age 24. In July 1944 while serving in the Southwest Pacific, this patient developed a rather generalized dermatitis which responded satisfactorily to treatment. However, a few isolated lesions, particularly one on the left lower leg and several about the perineum, were refractive to therapy and did not heal. On February 7, 1945, the patient developed a right peritonsillar abscess and was treated with sulfonamides. The abscess drained spontaneously and recovery was satisfactory. Three weeks later he noted that he was markedly weak and short of breath, had difficulty in swallowing and occasionally would regurgitate fluids through his nose. Shortly after, these symptoms were followed by tingling and numbness about the lips, hands, feet and legs. He rapidly became very weak and unable to sit without aid. He was first seen by the writer on March 8, 1945. On this date, the patient was pale, sweating profusely, and short of breath. Neurological examination revealed a nasal voice, inability of the right eye to converge, marked weakness, fatigability, and diffuse atony pronounced in the proximal girdle muscles, marked diminution in the deep tendon reflexes, and marked weakness in his extremities. Over the tip of the coccyx was an ulcer crater approximately one centimeter in diameter and one centimeter deep. This was covered with a gray, tenacious membrane. His pulse rate was 120. The blood pressure was 96/76. Heart sounds were distant and an easily detectable gallop rhythm was present. In any other than a completely prone position, the patient exhibited profound vascular collapse and his blood pressure could not be obtained. Smears and culture from both the throat and the ulcer described above yielded numerous colonies of *Corynebacterium diphtheriae* of marked virulence.

The patient was given 100,000 units of diphtheria

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antitoxin when first examined. In addition to this, he was given penicillin 10,000 units every two hours, and local irrigations of penicillin to the cutaneous lesion. Supportive therapy with adrenal cortex extract and intravenous glucose solution was also given during the critical stage of his illness. During the early part of his illness the patient, of necessity, was kept in an absolutely prone position. Elevation from this plane resulted in a sharp fall in blood pressure, syncope, and the clinical symptoms of shock. Final recovery was complete after four months.

The electrocardiogram obtained on March 9, 1945 showed an intraventricular block of the arborization type. There was rather marked loss of voltage of the QRS complexes in the limb leads, and the R waves were absent in the precordial leads. T1 and T2 were inverted. There was a slight depression of the RST segments in these leads. Frequent tracings were obtained, and by March 14, the T waves were inverted in all leads. The intraventricular conduction delay remained present until April 9, 1945 at which time the patient still had a profound peripheral neuritis. By July 7, five months from the time of admission, the electrocardiogram had returned to normal except for low voltage of the QRS complexes in the limb leads.

Case II. This 30-year old patient became ill on September 27, 1945 with a sore throat. He was first

seen and treated as an out-patient by means of topical application and penicillin spray to the throat. Showing continued symptoms, he was hospitalized on September 29, 1945. On this date he appeared acutely ill. His temperature was 100 degrees F. The pharynx was markedly injected; his tonsils swollen and covered with a grayish exudate. Other than for moderate cervical adenopathy, the physical examination was quite normal. Heart tones, pulse rate, and blood pressure were not unusual. Throat smears and cultures taken on September 28 and 29 were negative for specific organisms. Those taken September 30 showed *Corynebacterium diphtheriae* on both smears and cultures and, as was determined, the organism was quite virulent for the guinea pig.

During the fourth day of his illness, the patient received 60,000 units of diphtheria antitoxin intramuscularly. Improvement was prompt. All initial symptoms as well as signs of the throat lesion disappeared. As a matter of routine, an electrocardiographic tracing was made on the sixth day of his illness. It appeared quite normal. On the eighth day of illness, a mild palatal paralysis appeared. There were still no signs of cardiovascular damage. During the evening of the ninth day while using the bed pan, the patient suddenly became weak, nauseated, vomited and went into profound vascular collapse. The blood pressure could not be obtained.

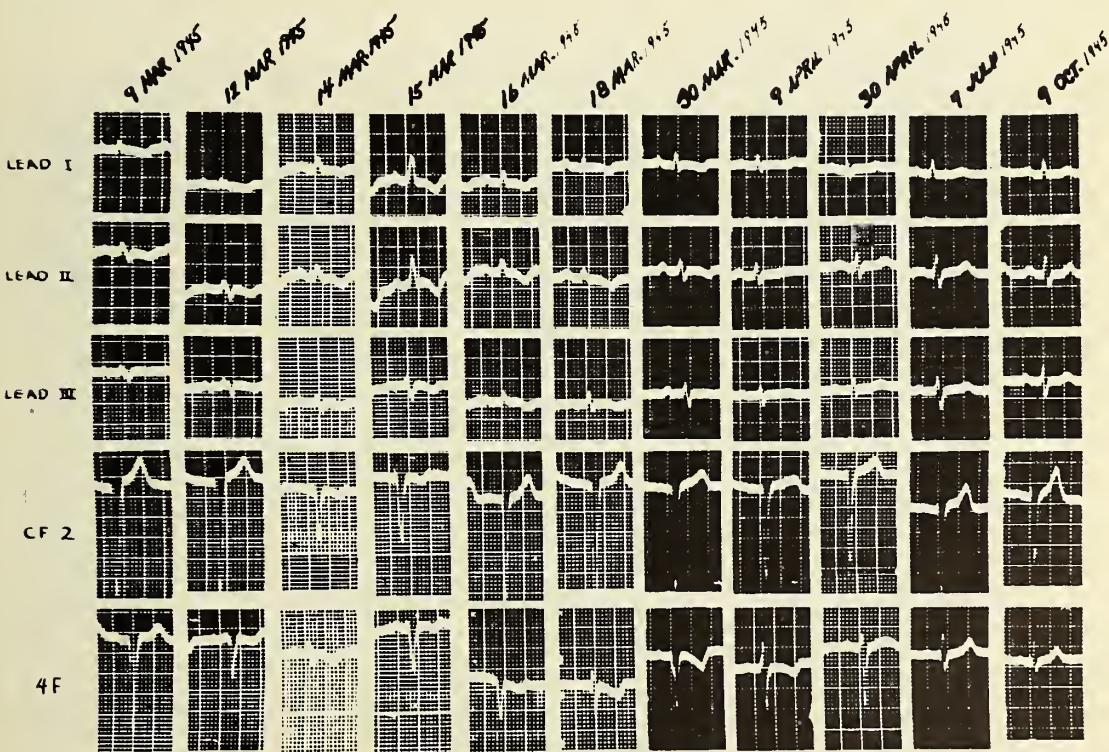


FIG I

his heart tones were muffled and distant, and a gallop rhythm was quite discernible. The pulse rate and respiration were not disturbed. The patient appeared in profound shock. He was pale, cold, lethargic, and in only vague mental contact with his surroundings.

With marked elevation of the foot of the bed and application of external heat, the patient immediately improved. He, however, could not tolerate even a horizontal position for many hours, and any attempt at raising to a sitting posture resulted in syncope. In addition to the above therapeutic measures, the patient was given cortical extract and intravenous glucose and these were continued for one week. The dosage of cortical extract was three cubic centimeters given three times during the first twenty-four hours, then one cubic centimeter three times daily. One thousand cubic centimeters of ten per cent glucose in distilled water was given daily during the same interval.

An electrocardiogram taken at the time of the first signs of vascular collapse revealed marked T wave depression and inversion. On October 22, associated ventricular block had developed. A marked loss of amplitude of the R wave in the chest leads was also noted. As may be noted in the tracings, practically

three months were required for a return to normal.

On about the twelfth day of this patient's illness, he had a clear cut post-diphtheritic polyneuritis as a further complication. This proceeded to total disability and involved all extremities. After forty-eight hours of a vascular atony, the patient slowly improved. His polyneuritis made the program of absolute bed rest easy to attain. Recovery was complete at three and one-half months.

**Case III.** This 24-year old soldier developed pharyngeal diphtheria on April 9, 1945, while a prisoner of war. Medical care unavailable, he received no antitoxin until the ninth day of his infection, at which time he received 40,000 units. Immediately prior to this a positive culture showing *C. diphtheriae* was obtained. Relief from the symptoms of the sore throat was prompt.

On May 23, 1945, the patient's first signs of complications developed. He first noted a nasal voice, regurgitation of fluids through his nose, followed by parasthesias of all extremities.

Three days later, on May 26, 1945, he was first seen by one of the observers (MHD). At that time the patient had a mild, early but obviously progressive, polyneuritis with all the required physical signs as well as spinal fluid findings. However, the cardio-

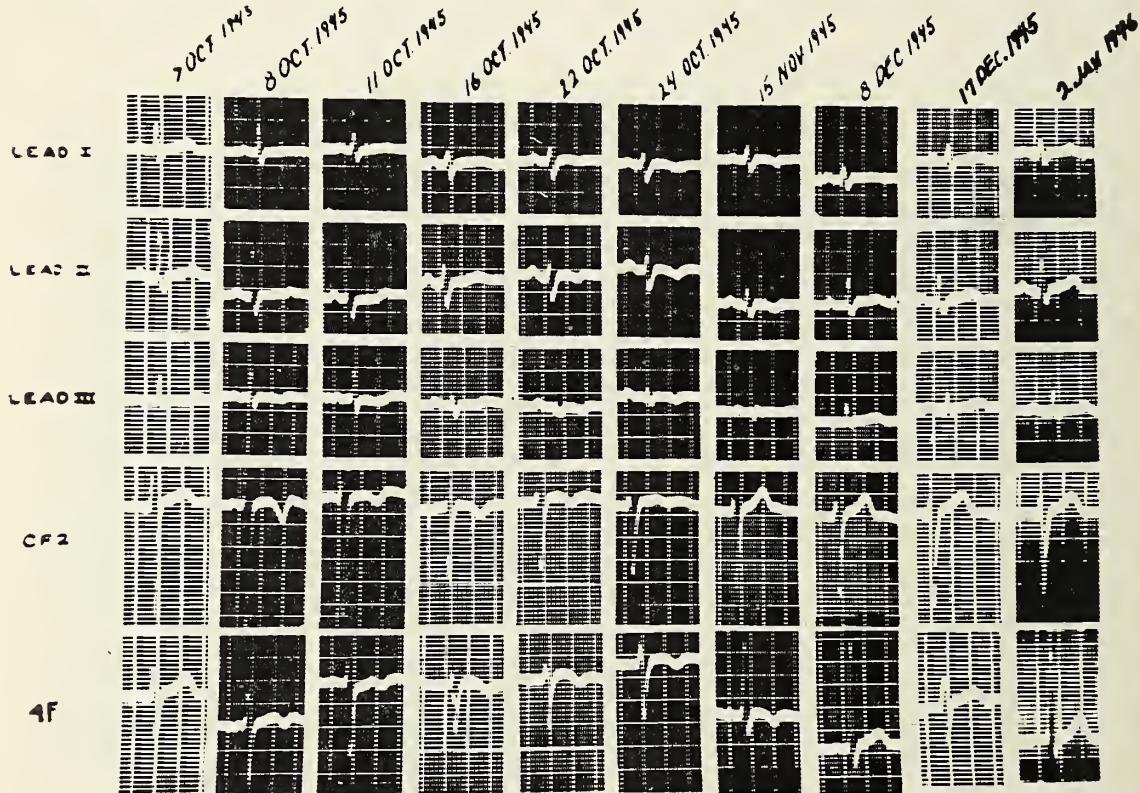


FIG. II

vascular examination was quite normal and remained so. It was only on routine and serial electrocardiographic examination that the myocardial changes were noted. The first tracings showed only a tachycardia. A tracing obtained on June 20, two and one-half months after the onset of his infection, showed a prolongation of the PR interval to .22 seconds and marked T wave amplitude loss. Convalescence was complete within four months, and electrocardiographic findings were normal.

#### THE ELECTROCARDIOGRAM

If dependence for diagnosis is based entirely on clinical findings, the presence of myocardial damage may be entirely unsuspected. Grave conduction defects may exist unrecognized. The importance of serial tracings can not be over-emphasized. Serious myocardial involvement can develop with alarming suddenness. In case II, a tracing was obtained on October 4, 1945, which was normal and the patient was apparently progressing satisfactorily, when he suddenly collapsed on October 7, 1945. An electrocardiogram was immediately obtained which demonstrated marked changes in the T wave. There has been a tendency to minimize existence of these T wave alterations in diphtheria<sup>4, 11</sup>. However, in

two of our cases, we observed that an abnormal T wave can be of grave importance and when found in the course of diphtheria, the patient should be confined to bed and followed with apprehension. In Case III, T wave flattening with prolongation of the auriculo-ventricular conduction time occurred with no clinical evidence of cardiac involvement. However, we feel that such cases should be treated expectantly and maintained on complete bed rest until all doubt concerning their cardiac status has been removed. Conduction defects have been reported as occurring in approximately 12 per cent of cases<sup>4</sup> and either an intraventricular conduction defect or complete auriculo-ventricular dissociation connotes a serious complication. Two of our cases had a delay in intraventricular conduction time, and the third had a prolongation in the AV conduction time. In Case II, the T wave inversion occurred approximately two weeks prior to the delay in the ventricular conduction time.

In two of our cases (I, II) the diminution or disappearance of the R waves in the chest leads was associated with the carditis. Marked loss of amplitude in the ventricular complexes was noted and on the whole the loss of amplitude persisted after the

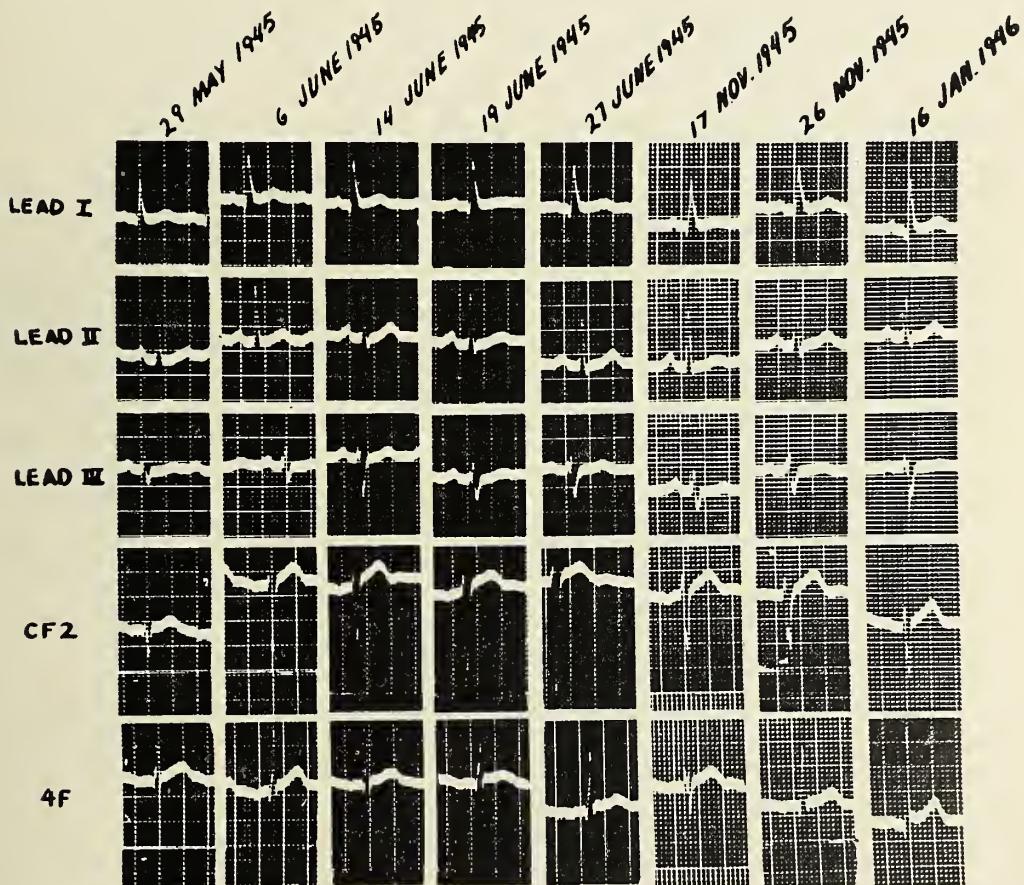


FIG. III

T waves and other changes had again become normal. Classically, it has been said that diphtheria is associated with sinus bradycardia. We did not observe this in these cases.

Case III has been included in this presentation although it is quite obvious that his clinical picture does not conform to our usual concepts for diphtheritic myocarditis. It must be emphasized that he had undoubtedly diphtheria proven by bacteriological studies. He received a very late and inadequate dosage of antitoxin. It was to be anticipated that a complication should develop from this long exposure to the unneutralized toxin. He did develop a profound polyneuritis with inability to even feed himself or turn in bed. It was only by routine study that the electrocardiographic changes were detected. In spite of this, we feel that these changes must be charged to the results of infection with *C. diphtheriae* and this alone.

#### DISCUSSION

The antiquity of diphtheria as a disease of man, the eminence of death from myocarditis, as well as the frequency of prolonged disability from polyneuritis, should keep the internist keen with appreciation of its danger. This maxim is not well heeded. Physicians have become dangerously lax in their appreciation of this once dreaded disease. No doubt such a situation has come about by the general belief that diphtheria is a disease of the past, that our program of immunization is universal, and that few numbers of our populace are susceptible. There is also the too freely accepted concept that the simple administration of antitoxin, regardless of the time element involved, immediately solves the problems of therapy. Such beliefs are quite unsound. Diphtheria, given new impetus by the war, is a common disease all too frequently unrecognized until one of its dangerous or fatal complications arise. This is particularly so in our young adult group of military age.

The possibility of diphtheria is to be considered in the differential diagnosis of every patient complaining of "sore throat." Smears and cultures should be routinely taken. The typical whitish, gray membrane may not be present or it may have been altered by local or systemic treatment with penicillin or the sulfonamides, and suitable bacteriological studies are a necessity. "Septic sore throat," "Vincent's Infections of the Throat," "Infections Mononucleosis," all may tax diagnostic abilities and end in bitter error unless accompanied by proper and careful bacteriology. Suggestive of diphtheria is fever of mild or moderate elevation associated with a high white blood cell count. If these appear in a child or young adult more toxic than seems compatible with severity in appearance of the throat, suspicion should be even

greater. Nasal and laryngeal lesions can be easily overlooked and add to confusion in making an early diagnosis of diphtheria.

It is to be borne in mind that in each case in which the disease develops myocarditis may follow. A preliminary electrocardiogram may be quite normal only to show marked changes later. Typically a patient apparently progressing nicely suddenly shows evidence of profound vascular collapse. He becomes pale, clammy, lethargic, nauseated, and often complains of severe abdominal pain. Upon physical examination his blood pressure may be so low as to be unobtainable, the pulse slow, weak or imperceptible. The observer is struck by the patient's marked pallor and apparent weakness. The respiratory rate will rarely be disturbed. Other signs are quite absent. It is our belief that these preliminary signs of cardiovascular complications, appearing about the seventh to ninth day are, in reality, evidence of peripheral vascular involvement.

Successfully passing this critical stage, the patient enters a more serious phase about the 14th day and may remain so for another two-week period. The latter phase is accompanied by more marked electrocardiographic changes indicative of severe myocarditis, i.e., loss of amplitude of all complexes, marked T wave inversion and conduction defects. During this period the possibility of serious arrhythmias developing is great. Once the diagnosis of myocarditis is made the prognosis is grave but improves with each day passed.

Prophylactic treatment in its most desirable form—active immunization, represents an ideal to be attained. This, combined with a suitable program of Schick testing for determining susceptibility, has been accomplished in a far too small segment of the population. The desirability of wider application of such preventive medicine is obvious and requires no further comment.

The infected patient must have early recognition of his disease for the most efficacious use of diphtheria antitoxin. Given no later than the third day of illness, antitoxin is highly protective. Each day after this, the greater is the opportunity for the diphtheria toxin to have fixed itself in an irreversible fashion within myocardial and neurogenic tissue. If such occurs, no amount of antitoxin can give assurance of freedom from complication. What constitutes adequate dosage of diphtheria antitoxin must rest with the physician. It will usually vary between forty and one hundred thousand units.

Of equal importance with early recognition of the disease is careful watching of the patient for the early signs of vascular failure. This procedure should include regular checking of the blood pressure, pulse and heart tones. A preliminary electro-

cardiogram with subsequent tracings for comparison is valuable. With the first evidence of falling blood pressure, we have found that the old and simple but almost forgotten procedures of elevation of the foot of the bed, external heat, and the administration of hot liquids, are more effective than any other routine therapy during this critical collapse stage.

Hayne and Welford<sup>6</sup> have emphasized the value of intravenous glucose solutions for the patient with diphtheritic myocarditis. One thousand ccs. daily of ten per cent glucose in water can be given slowly and with a minimum of danger to the patient. Its use until the patient is definitely improving is warranted.

There is much doubt regarding the efficacy of any drugs in diphtheritic myocarditis. During the early stages, we have found adrenalin to be definitely contraindicated. Even in small dosages this drug may accentuate the shock state. During the late manifestations of full blown myocardial involvement with conduction disturbances, adrenalin may be useful. Ephedrine, we feel, falls into the same category. We have used cortical extract with no concrete evidence that it maintains blood pressure.

Absolute bed rest with a minimum of position change on the part of the patient throughout the critical phases of a diphtheritic myocarditis, is absolutely imperative. We have found that such simple maneuvers as raising upon the elbows, turning to the left side, and sitting upon a bed pan may precipitate a profound and dangerous syncope. This protective requirement of absolute quiet should con-

tinue well into the fourth week for all patients developing myocarditis.

The prognosis in diphtheritic myocarditis is that of diphtheria since practically all deaths are the result of this complication. A mortality of about ten per cent is generally observed. Death may be due to vascular collapse, fatal arrhythmia, or the less common cerebral complication—thrombosis, following primary cardiovascular damage. The fortunate patient makes a complete recovery with no electrocardiographic or clinical evidence of residuals.

#### SUMMARY

1. Three cases of diphtheritic myocarditis are presented with accompanying preliminary and follow-up electrocardiographic tracings.
2. A brief resume of the pertinent literature has been made.
3. Diphtheria must be recognized as a disease continuing to be a great menace.
4. Early diagnosis by adequate bacteriological studies, prompt administration of antitoxin and meticulous management of the patient are all factors in a favorable outcome.
5. The simple procedures of elevation of the foot of bed, external heat, administration of warm liquids, and absolute rest constitute the most effective treatment of the early peripheral vascular collapse state.

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The Committee (Tuberculosis Committee of the American Student Health Association) believes there is ample evidence to justify the following statements relative to case-finding procedures commonly employed among college students:

1. The incidence of tuberculous infection among college students is steadily decreasing. The majority of reports from colleges in 1943-44 indicate infection rates varying between 15 and 30 per cent.

2. The two-dose Mantoux method is recommended as the method of choice for tuberculin testing. If a single test dose is employed, an intermediate dose of at least 0.1 mg. O.T., or 0.0001 mg. P.P.D. should be used. The Vollmer patch test cannot be recommended for use in colleges.

3. The Mantoux test is highly dependable in eliciting sensitivity due to significant tuberculous infection or disease. It is sound practice, and in the interests of economy, to provide chest roentgenograms for only those students who react to an adequate dose of tuberculin.

4. Complete protection against tuberculosis for college students cannot be attained through a program limited to the student body. Faculty members and employees, including food handlers, should participate in the tuberculosis control program on the same basis as students.

5. The lesions of pulmonary tuberculosis encountered

in college students are, in a majority of instances, unstable and potentially dangerous. The absence of symptoms does not preclude the necessity for early treatment. Students who remain in college having pulmonary lesions, should be under close observation with frequent clinical and roentgenographic studies.

*Tuberculosis Among College Students, H. D. Lees, M.D., The Journal-Lancet, September, 1945.*

The treatment of palpitation is the treatment of the cause. Each case should be investigated from the standpoint of a possible disturbance of the rhythm of the heart and, hence should be seen when the symptoms are present if possible. One should also search carefully for thyrotoxicosis, anemia, low-grade infections, and for hypoglycemia. If these several conditions can be eliminated and if the patient presents the personality picture of an anxiety state, the chances are strong that the condition is psychogenic in origin. Most of the causes of palpitation can be treated with fair success and their recognition depends on a thorough examination of the patient as a whole, and more particularly on a painstaking history as to the exact circumstances under which the symptom occurs.—T. R. Harrison, M.D., in the Texas State Journal of Medicine, January, 1946.

## PRESIDENT'S PAGE

*To the Members of the Kansas Medical Society:*

Your president and executive secretary have just returned from a two-day regional conference in Denver on Industrial Medicine and Medical Service and Public Relations. There were many interesting presentations in this A.M.A. sponsored meeting, but the outstanding event was the opportunity to meet and see in action Dr. George F. Lull, the new secretary and general manager of the American Medical Association.

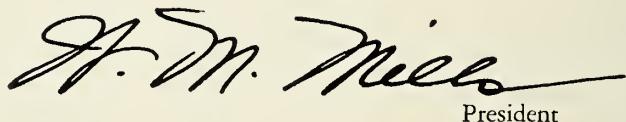
We wish to congratulate our national organization on its new director and to extend to him the best wishes of the Kansas Medical Society.

Doctor Lull has a long and varied background of administrative work in the medical field that has received the highest recognition. His approach to his present job, which includes direct contact with regional and state groups, is winning many personal friends and composing past differences.

It was a pleasure to see him sitting through a long meeting and taking notes on every suggestion. He has already appointed a committee to work out a medical personnel plan in case of another national emergency which will seek to avoid the inequities that existed as the result of inadequate forethought and correlation of various agencies in the recent war.

Doctor Lull symbolizes the changed and liberalized attitude of the American Medical Association toward all the plans for extension of medical service to the public. We have now not only tolerance but real cooperation in our state enterprises.

It is also noteworthy that Doctor Lull indicated his willingness to attend our 1947 state meeting. This will give the committee a good start for a fine program.



H. M. Miles

President

## EDITORIALS

### The Nation's Health

There is a committee entitled the Committee for the Nation's Health. This committee's headquarters are in New York City. It has an office in Washington. Its chairman is Channing Frothingham, M.D. It lists among its honorary vice chairmen such notables as William Green, Philip Murray, Mrs. Franklin D. Roosevelt and David Sarnoff. Strangely enough, out of the names of one hundred eighty persons, printed on their stationery, assuming that these persons are members of or supporters of the "Committee for the Nation's Health," there are only nine doctors of medicine and five doctors of dentistry. Offhand it seems a little strange that a "committee" concerning itself with the nation's health would consider itself competent to weigh the problems of the nation with less than eight per cent of its letter-headed membership belonging to the medical and allied professions.

On April 23, 1946, over the signature of Channing Frothingham, M.D., chairman of the "Committee for the Nation's Health," we received a letter containing an enclosed fact sheet, the purpose of which was to provide us with background material concerning the nation's health needs. A few of these published "facts" will be quoted and discussed in the following paragraphs.

"FACT: Existing medical facilities and services cannot cope with America's urgent health needs. Over 40 per cent of the nation's selectees were found unfit for military duty." This last statement is certainly worn out and, like all statistical data, does not mean anything until it is broken down, analyzed and classified. Nor does it mean that under any system of medicine be it "political" or otherwise that this percentage of rejectees could be lowered when examined under the exacting physical standards of the services. In italics under the same heading is this statement: "In 1944, 15,000 crippled children were on waiting lists awaiting unavailable crippled children's care from state agencies." It failed to mention, however, that in 1944 medicinal practitioners were on the critical list and that the many thousands of doctors who would ordinarily do this work were performing the immediately more urgent duties of caring for the sick and wounded of the varying branches of the services. It would take the most flighty stretch of one's imagination to reach the conclusion that the civilian M.D.'s in 1944, being hamstrung and hog tied by governmental red tape, even under the decentralized administration program as proposed by the Wagner-Murray-Dingell

bill, could have increased their effort output as far as the nation's health is concerned.

"FACT: Despite our great progress in medical techniques, we lag behind other countries in many health records. Seven countries had lower infant mortality rates than the United States (years immediately preceding World War II). From seven to eleven countries had lower death rates among children." In comparing statistics from varying nations, those statistics must have the same yardstick for their measurement. They did not mention that at least one of those countries has legalized abortion which prevents the birth of unwanted children. "Twenty or more countries had lower death rates among persons aged 35-64." The committee did not discuss the deaths from accidents in the greatest mechanized country in the world. They did not consider the tremendous social and economic pressure under which the American people thrive, survive and many die before their years. Can we assume that the Wagner-Murray-Dingell bill will alleviate those hazards?

"FACT: Nothing short of passage of the Wagner-Murray-Dingell bill will provide for the nation's health needs." That is the most absurd statement we have ever heard. To print a statement and label it as a "FACT," until there is at least a trial run is ridiculous. "Voluntary health insurance plans will not meet the needs." "The health insurance plans sponsored by medical societies operate in less than half the states, have not given evidence of extensive growth, usually offer only limited services at relatively high cost and their management includes no representation of the people who pay the bills." At least voluntary insurance plans such as ours offer a contract for a definite amount of medical service for a certain designated sum of money per year. For \$27.00 per year, a contractee gets for himself and family maximum medical services amounting to \$1,000 per contract year. According to Washington statisticians, a payroll levy of four per cent has been estimated as the minimum for carrying out the national plan. You will note the statement, estimated minimum. Thus, a married man with two dependents earning \$3,000 a year would pay an estimated minimum of \$120 a year for medical care. And they speak of medical society voluntary insurance plans being at a relatively high cost. They also mention the fact that the man who pays the money has no representation in the management. It is again difficult to imagine just how much representation the individual tax payer in the isolated county or town will have in a "politically supervised and controlled plan." He can, at least, cancel his contract with the voluntary insurance plan, but with political medicine he will pay because he has to, and hope. Dorothy

Thompson in one of her articles made the statement, in discussing Wagner Bill No. 1606, that "the expenditure for ink will exceed that for iodine."

We, as Americans, have grown up under the idea that this is the "Land of the Free and the Home of the Brave." Let us hope that we continue to be free from "Political Medicine." Let us hope that each one of us remains an individual and, as an individual, that we are our own keeper. Let us hope that we can preserve the dignity of our own self respect to the end, that we can say that we have provided our families with food, clothing and health. Let us hope that those who represent us in Washington are brave and will defeat political medical schemes and return the right and privilege of health to the individual, where it belongs.

### Committee Appointments

Among the first major duties of a Society president is the appointment of committees. Few members realize the care and thought that go into the preparation of this list. Each president attempts to place members on committees in which they are genuinely interested and tries to name his selections on a geographical basis as well.

This year Doctor Mills has attempted to give many places of responsibility to members returned from service in the hope that service men will take an active part in guiding policies of the Society for the future. It is his sincere belief that their experience and thinking will be of great benefit to the various committees during the coming year.

It is impossible to appoint each member of the Society on a committee. Therefore, many names that should have appeared have had to be omitted. It was intended that no member serve on more than one committee, but exceptions have been made in a few instances when the committee chairman was eager to have certain men working with him. Doctor Mills asked the assistance of each chairman in naming members of committees and in several instances it happened that more than one chairman listed the name of the same physician.

Some committees previously appointed have been omitted this year, such as the Committee on War Participation and the Committee on Locations. These have not been appointed by reason of the fact that their work has largely been completed. In their places, however, several new committees have been named. This was done because in certain fields specific problems exist that will require attention.

On Page VIII of this issue may be found the complete roster of committee appointments. Suggestions have already been received for other committees which might be added. Any comment regarding committee activities or on the formation of

additional committees will be welcomed now or at any time during the year. Suggestions may be sent directly to Doctor Mills or to the Executive Office, from where they will be forwarded. Any member wishing to attend committee meetings is welcome to do so and to enter freely into the discussion.

### Locations

Since the close of the war, a list of Kansas locations needing medical care has been compiled and maintained at the Executive Office. Doctors returning from service have been invited to inquire at the Executive Office for locations that are especially attractive. During the past year, many doctors have availed themselves of this service and have located in many of the communities that were considered critical during the war.

The Kansas medical situation has changed within this past year until today there are few extensive areas without adequate medical care. There remain in the state three counties that have no doctor of medicine and a few cities of 2,000 and more that need doctors. Most requests for physicians now come from small towns.

These smaller communities often present highly attractive locations. They are frequently situations where doctors have had a splendid practice, communities that support a doctor well and which, after the death or retirement of their doctors, are now hoping to welcome new doctors of medicine to take their place. Except for size, which tends to reduce the outside activities that are available, these communities are more desirable in many ways than some of the larger cities.

There is a variety to select from. For instance, a town with a present population of 300 will shortly become an industrial city of 2,000. This town has no doctor at present and offers a combination of industrial and private practice. Another city of over 1,500 offers to buy and loan to a doctor moving into the community all equipment, including surgical supplies. This equipment is to be used in his office until a splendid new hospital, the bonds for which are already approved, can be built. Then the equipment becomes the property of the hospital. One city that recently supported three doctors is now without medical care. And there are many more.

The list of Kansas locations includes requests that come from the medical profession as well as many from the community, the Chamber of Commerce, or other responsible organizations. Letters from the community often give a clear picture of what the community wants and what it has to offer, as illustrated by the following excerpt: "We are keenly interested in the establishment in this promising

community of the following medical profession: A (horse and buggy) doctor and a dentist.

"We use the term horse and buggy with reservation, but what we wish to convey is that, since this is a very small town, a practice must of necessity be developed from the countryside. And the countryside is good—the valley is a fertile one and gives promise of a greater future. However, the doctor and dentist we are looking for must have a generous amount of the old pioneering spirit in his make-up. He must have vision and foresight and not be too proud to live in a small place. For such a one there is ample opportunity."

The letter closes with a description of a building with nine big rooms available for use. This is one of numerous requests that are still on file. These locations are waiting for doctors to move in. The Executive Office of the Kansas Medical Society, 406 Columbian Building, Topeka, Kansas, will be glad to assist any doctor interested in locating in this state.

#### **Amendments Approved at State Meeting**

Three amendments to the Constitution and By-laws of the Kansas Medical Society were approved at the second meeting of the House of Delegates during the 1946 annual session at Wichita, and one proposed amendment was rejected. The three amendments approved on April 25, 1946, are printed below.

##### **Constitution, Article II, Purposes of the Society.**

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the state of Kansas, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to advocate the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; to enlighten and direct public opinion in regard to the great problems of state medicine so that the medical profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

##### **By-Laws, Chapter V—House of Delegates—Section 12**

It shall consider and advise as to the material interests of the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall advocate all proper medical and health legislation and the diffusion of popular information in relation thereto.

##### **By Laws, Chapter XI—Committees—Section 24.**

The committee on Public Policy shall consist of at least three members and in addition the president-elect and the secretary. Under the direction of the House of Delegates and the Council it shall represent this Society by keeping in touch with professional and public opinion and advocate legislation to secure the best medical results for the whole people and promote the general good of the community in local, state and national affairs and elections. At least one member of this committee shall have served on the retiring committee.

#### **Twenty-five Years of Progress**

The American Journal of Obstetrics and Gynecology observed the 25th anniversary of its founding last December, and in commenting on the occasion Dr. George W. Kosmack, editor, outlined some of the accomplishments of the period. Quoted below is a portion of his editorial.

"During this past quarter of a century, medicine has participated in the revolutionary changes which have affected the entire world. We have seen, above all, the effect to make medical advances more available to all of the people, with a resulting expansion of governmental direction and control. The extension of direct medical service to a certain group of the people, as exemplified by the Emergency Maternity and Infant Care program, may be but the first of a succession of projects by which maternity care finally is to be provided through governmental funds for any woman who requests it. It is understandable that the fields of obstetric and pediatric practice should be the first to receive such attention, for there is a sentimental factor involved in caring for the Nation's mothers and children. These special fields may, however, serve simply as an area in which such measures are the first to be tried, and serve as a forerunner, perhaps of the extension of government activity in other branches of medicine. Whether such expansion from previous accepted methods will prove either desirable or beneficial is for the future to decide. There remains a lingering doubt in the minds of many physicians whether such measures, centrally controlled in the final analysis by a bureaucratic administration in the national capitol and supported by universal taxation, will bring about that practical idea in maternal and infant welfare which we all desire."

#### **New Process for Synthesizing Methionine**

A new commercial process for synthesizing one of the essential amino acids was announced recently by Glenn Haskell, president of U. S. Industrial Chemicals, Inc., New York. The amino acid, known as methionine, is one of the ten amino acids considered essential for growth of man and animals. Recent research reports indicate wide medical application of this chemical, particularly for treatment of the liver.

Methionine has previously been available only in minute quantities and at a cost of several hundred dollars a pound. The new process should reduce the cost about 97 per cent and make methionine available for the number of important medical uses already known and for many others now under study,

In the treatment of peptic ulcers, as well as in the cure of thousands of near-fatal starvation cases in Europe, amino acids as present in the so-called "predigested proteins" are reported to have had dramatic success. One of the big uses foreseen for methionine is in fortifying those compounds to still further increase their effectiveness.

A motion picture in color depicting in detail an abdominoperitoneal proctosigmoidectomy has been obtained by the medical department of the Frederick Stearns and Company Division, Sterling Drug, Inc., according to Dr. Earl S. Burbridge, director. It is available for showing by hospitals, medical societies and other interested professional groups on application to John Seward, manager of the professional service department, at Stearns headquarters offices, Detroit, Michigan. The showing time of the film is 38 minutes.

## EXECUTIVE OFFICE

### Federal Legislation

In no way intending to minimize the importance of the Wagner-Murray bill, S. 1606, this discussion will concentrate on other Federal measures primarily because less has been written about them. The Wagner bill is not nearly the only measure affecting medicine that is today under consideration by the Congress.

Some are impractical to the point of absurdity and for obvious reasons will require no particular attention on the part of the medical profession. Take for example S. 1883 offering an appropriation of \$3,750,000,000 for prevention and treatment of cancer, or S. 1888 appropriating \$3,750,000,000 to combat infantile paralysis. This bill states that "the funds authorized to be appropriated . . . shall be dispersed by the Secretary of the Treasury upon vouchers approved by Sister Kenny." Perhaps S. 1891 is a better illustration of this point. This bill attempts to provide means for securing a specimen of the urine of each person in the United States "not more often than once in every six months."

### The Pepper Bill, S. 1318

This bill now resting in the Committee on Education and Labor is potentially as serious a threat to the freedom of the medical profession as any measure before Congress at present.

### Hill-Burton Bill, S. 191

This is known as the Hospital Construction Act. It has passed the Senate and hearings are being held in the House. Many features of this bill are desirable and for the benefit of the public. Certain people are now attempting to attach amendments to this measure, which should be watched. The Hospital Construction Act is not entirely desirable. It leaves open the possibility for considerable Federal influence after the hospitals are constructed. One representative has suggested that should hospitals be built with the use of funds provided by this measure and should they be unable to continue operation, it would be an easy matter for the Federal government to take over those hospitals and operate them. This bill also tends to take away from communities the initiative of providing their own hospital care. In spite of a few areas where hospital shortages exist, most communities have found means to provide hospital facilities.

In Kansas the hospital building program has already received impetus by the last session of the Kansas legislature, which passed enabling legislation permitting any county and any city of the first or second class to vote bonds for the construction of hospitals. In numerous communities these bonds have already been voted on. Other elections will be held in the near future. When materials become available these hospitals will be built, regardless of whether or not Federal aid is available. Therefore, one wonders just what the opinion of the majority of the doctors in Kansas would be concerning the necessity of this bill.

### The Taft Bill, S. 2143

On May 3 Mr. Taft, for himself, Mr. Smith and Mr. Ball, introduced into the Senate of the United States this measure to be known as the National Health Act of 1946. Senator Taft had consulted with many doctors of medicine, including some from Kansas, during the months he was compiling material for this bill. Being completely

opposed to the Wagner-Murray bill, he has created this as an answer. It is designed for two purposes, the first being to counteract S. 1606 with a positive answer. The second represents an attempt to correct certain difficulties that have been experienced in the past in the administration of medical affairs on the Federal level.

The introduction to the bill states that it is designed "to coordinate the health functions of the Federal government in a single agency; to amend the Public Health Services Act for the following purposes: To expand the activities of the Public Health Service; to promote and encourage medical and dental research in the National Institute of Health and through grants-in-aid to the states; to construct in the National Institute of Health a dental research institute and a neuropsychiatric institute; and for other purposes."

There are perhaps five major items contained in this measure which will be discussed here. Other discussions will be carried in the Journal of the American Medical Association and in other places.

The first provision is to create in the executive branch of the government an agency to be known as the National Health Agency. The president shall appoint a National Health Administrator who shall receive a salary of \$15,000 per year. The administrator shall be a doctor of medicine with at least eight years experience in the commissioned corps of the Public Health Service or with five years of active practice and three years of experience in a responsible position in medical research, teaching or administration.

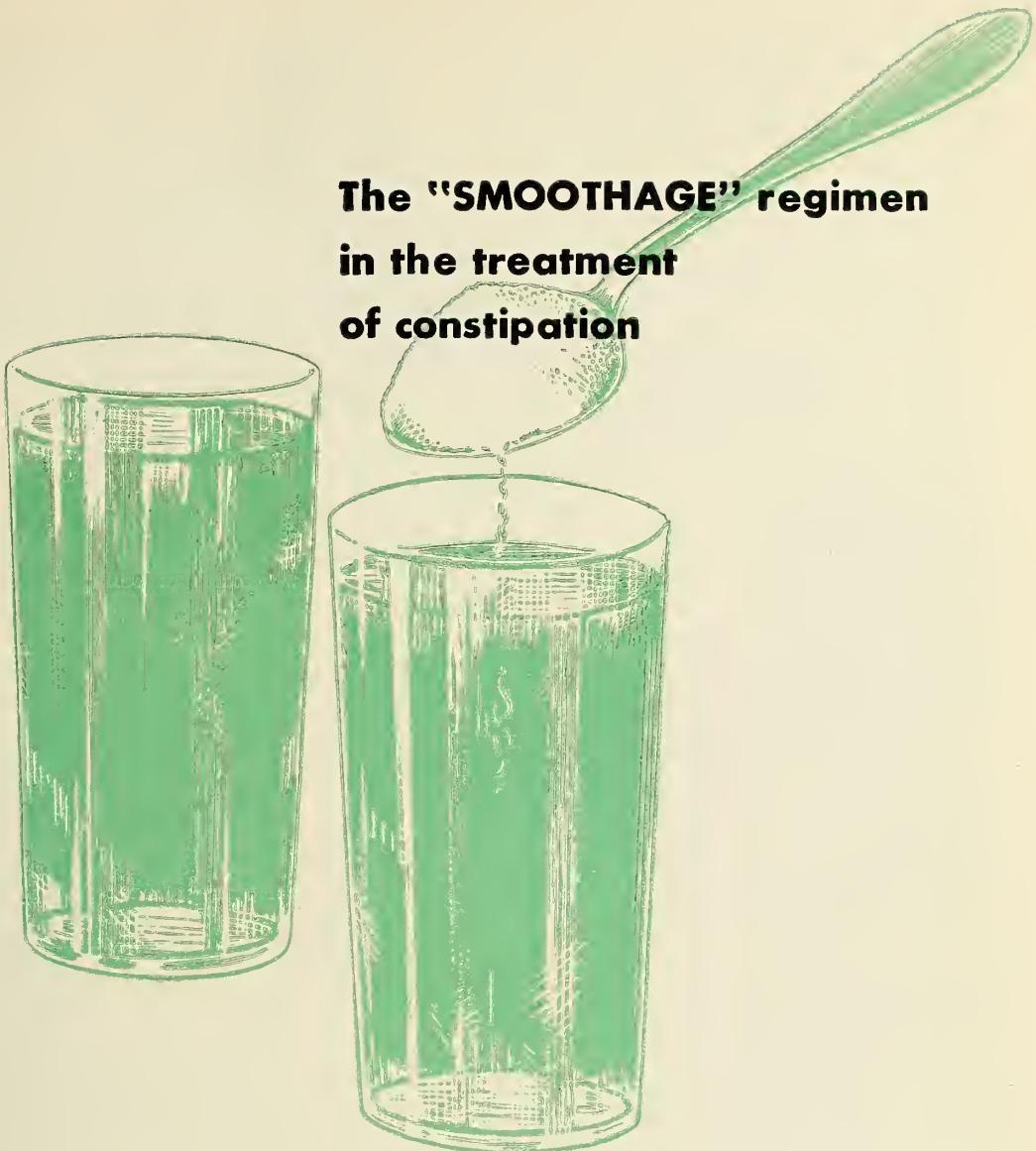
In this agency shall be centralized the activities of the Federal government relating to health. Transferred to the National Health Agency shall be the Public Health Service, St. Elizabeth's Hospital, the Food and Drug Administration, and the Office of Vocational Rehabilitation, including all personnel, functions, power, duties and unexpended appropriations. Transferred to this agency also are that portion of the Children's Bureau dealing with health matters and the Division of Health Studies in the Bureau of Research and Statistics of the Social Security Board. From these agencies also will be taken office equipment and records as well as personnel and unexpended appropriations.

The National Health Agency shall encourage the development of health services and facilities. It shall advise and cooperate with public and private agencies functioning in the field of health. The agency shall collect and analyze statistics on conditions, problems and needs in the field of health in the United States and other countries and shall make this information available. It shall make recommendations on policies and methods for the promotion of health and related services with respect to legislative and administrative policy and shall carry out such other duties as the Congress may subsequently enact.

The National Health Agency shall also administer specific projects such as the labeling of foods, drugs and cosmetics, the training and rehabilitation of persons vocationally handicapped, etc. In general this agency shall "aid the states and the people of the United States in the maintenance of adequate and efficient health facilities and otherwise promote the national health."

This agency shall consist of numerous divisions, of which several shall have advisory councils appointed by the administrator. These are regulated in part so that at least three out of eight members shall be doctors of medicine.

The second major consideration relates to medical services. The bill asks an appropriation of \$2,000,000 for each of the next five years to assist the states in providing health, hospitals and medical services for families of low



## The "SMOOTHAGE" regimen in the treatment of constipation

A rounded teaspoonful of Metamucil stirred into a glass of water, milk or fruit juice, three times a day, provides the soft, mucilaginous bulk which is desirable for natural elimination. Metamucil contains no roughage, no oils, no chemical irritants.

**Metamucil** is the highly purified, nonirritating extract of the seed of the psyllium, *Plantago ovata* (50%), combined with anhydrous dextrose (50%). It mixes readily with liquids, is palatable, easy to take.

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RESEARCH IN THE SERVICE OF MEDICINE

income. Each state wishing to receive money from this appropriation must designate a single state agency to administer the plan, must have an advisory council, and must set forth a state-wide program to include health inspection services for all children in elementary and secondary schools in the state.

If the state wishes, this money may be used to provide medical care in the home or physician's office for families with low incomes. These benefits may be distributed by means of paying the premiums or partial premiums "to any voluntary health, medical or hospital insurance fund operated not for profit." If a state wishes, it may make annual payments to physicians in areas that without such payments could not provide sufficient income to attract a practicing physician. There must be no discrimination as to race, creed or color. The only restriction is that persons receiving this benefit must be considered unable to pay in full for the services provided.

Each state participating must supply at least twice the amount of the Federal aid it is to receive for this program. Senator Taft states that "it is intended that the state shall devise in each case the method by which this end is attained." When an unexpended balance remains at the close of a fiscal year, it may be kept for one additional year and if then is not used must be returned to the Federal treasury. Wherever a state disapproves of the action of the Surgeon General of the United States Public Health Service, provision is made for appeals.

This entire program is to be administered by the Surgeon General of the United States Public Health Service, who is authorized to make such administrative regulations as he finds necessary. He is directed to "consult with the National Health Council of eight members, at least three of whom shall be doctors of medicine."

The third major item provides an increased amount for each year up to \$20,000,000 a year for dental health services in a manner similar to that outlined for medical services.

Fourth is a provision to aid dental research and training which is similar, except in amount, to that described in the next section.

There is to be created a National Advisory Council on medical research. The Surgeon General of the United States Public Health Service shall be chairman with six members to be appointed from leading medical or scientific authorities who are outstanding in the study, diagnosis or treatment of mental or neuropsychiatric disorders. Three shall be doctors of medicine and the other persons shall be thoroughly familiar with neuropsychiatric conditions and problems in the United States.

There shall be established in the National Institute of Health a division to be known as the National Institute of Neuropsychiatric Research. This institute shall work in research, shall promote coordination of research conducted by public and private agencies, shall provide scholarships in the institute, shall review applications from universities, hospitals, etc., "whether public or private or from individuals for grants-in-aid," and may make recommendations to the Surgeon General. Donations may be accepted for the carrying on of such work. Any donation of \$50,000 or more will be acknowledged by the establishment of a memorial. For these combined projects \$1,200,000 is to be appropriated each year after 1948.

There shall be constructed in or near the District of Columbia a suitable hospital, laboratory and related facilities for the use of the National Institute of Neuropsychiatric Research at a cost not to exceed \$4,500,000.

Another project includes a yearly appropriation of \$4,500,000 for grants-in-aid to universities and for medi-

cal research in the National Institute of Health, and finally it is provided that any officer or employee of the government of the United States who requests the government to deduct from his salary the cost to be paid to any public or private health insurance fund may have this amount deducted. This shall include any non-profit organization undertaking to insure persons against the expense of hospital, medical or dental services or any service connected with health.

The bill S. 2143 has been summarized without comment although many thoughts come to mind concerning possible situations that might arise if legislation of this type is enacted, and although amendments might radically alter the program here proposed. This column is not in position to offer critical suggestions. It is recommended that each member study this measure to determine for himself the meaning of this bill. Suggestions will be welcome.

### State Responds to Cancer Campaign

Kansas was one of the first states to reach its goal in the 1946 cancer control campaign, contributing a total of \$131,396 with some funds still to come in. This amount is \$20,000 more than the Kansas quota.

### Predicts Control of Virus Diseases

Dr. Selman A. Waksman, who discovered streptomycin, predicts that the time is not far off when such diseases as the common cold, infantile paralysis and tuberculosis will be brought under practical control through the enlargement of medical knowledge and the development of new drugs.

Within a period of five years, he says, we have witnessed the development of radically new methods of treating a variety of diseases. The possibilities are just being explored and there is promise of greater things in the future, notably in finding agents to combat a great variety of diseases against most of which no effective agents are known at present.

### New Auxiliary Publication

The Council of the Kansas Medical Society, at its meeting at Wichita April 25, approved plans for the publication of a quarterly bulletin for the Woman's Auxiliary to the Kansas Medical Society. The copy for the first issue is now being assembled, and Volume One Number One of the new bulletin will be mailed to all members of the Auxiliary in a few weeks. Thereafter the bulletin will be printed during the last month of each quarter.

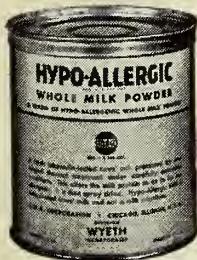
The new publication will fill a need that has long been apparent, and the members of the Auxiliary are enthusiastic over preliminary plans. All articles for the bulletin will be prepared and assembled by the Auxiliary, and all publication details and expenses will be the responsibility of the Society. Since the bulletin will be a direct means of reaching all members of the Auxiliary, their usual page in the Journal of the Kansas Medical Society will be omitted in the future.

### Schering Announces Award

The Schering Corporation has announced that the subject for this year's contest thesis will be "The Role of Hormones in Sterility." The contest is open to any undergraduate medical student in the United States or Canada. An award of \$500 will be given for the best thesis, \$300 for the paper judged second and \$200 for that ranking third.



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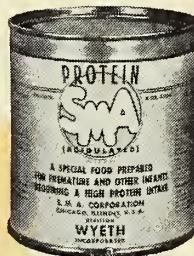
Particularly suited for infants and children allergic to cow's milk protein, Hypo-Allergic Milk has been rendered less allergenic by means of prolonged thermal processing. When reconstituted with water it is used in the same proportion as whole cows' milk.

POWDER—1 lb. tins

*Use one of these Special Infant Foods*

LIQUID 14½ oz. tins

### High Protein

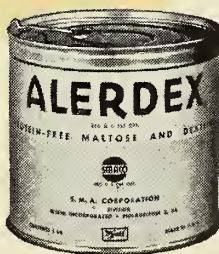


### PROTEIN S-M-A\* (Acidulated)

The easily digested curd and liberal vitamin content makes Protein S-M-A a valuable aid in the management of premature and undernourished newborn infants. Also indicated in infant diarrhea and other conditions where a high protein intake is required.

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### ALERDEX\* Protein-free Maltose and Dextrans

An all-around milk modifier especially useful in the hypo-allergenic milk diet of the infant sensitive to proteins, Alerdex is prepared from noncereal starch by a special procedure to eliminate every trace of protein.

POWDER—16 oz. tins

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## Veterans' Administration Agreement

Almost two months of experience with the new Veterans' Administration program has given the Kansas Medical Society and the Veterans' Administration an opportunity to see how the plan will work. Up to the present everyone is pleased with the results. The program in Kansas is working smoothly and has already served numerous veterans.

On May 24 Lieutenant Colonel Gibbons, director of the Veterans' Administration Medical Service Center, reported that approximately 526 cases had been handled through his office since April 1. This represents only completed cases. In addition, there are about 200 approved for examination or service but not completed. One hundred thirty-two cases have been approved for treatment for service-connected disabilities, of which 26 were hospitalized in private hospitals.

The special committee authorized by your council to supervise this program has been named the Committee on Veterans' Administration Affairs. Topeka representatives on this committee meet with Colonel Gibbons each Friday noon to go over problems that have arisen during the past week. Unusual claims and incomplete examination blanks are brought to the attention of this committee. Letters are then sent in the name of the committee to those physicians, requesting alterations to be made.

Surprisingly few incomplete Veterans' Administration Medical Form 2545's have been received. Even in Veterans' Administration hospitals where a staff of physicians makes these examinations regularly, there are frequent errors requiring the form to be returned. It is the ambition of the Committee on Veterans' Administration Affairs of the Kansas Medical Society to check these so thoroughly that no 2545 needs to be returned after it reaches the regional office. Letters occasionally sent to examining physicians are not reprimands. This committee is charged with guaranteeing the quality of service rendered. The committee attempts to perform its services well and requests the co-operation of the profession.

The program is new and some time will elapse before all members can become familiar with the requirements involved. Occasional announcements will be carried in the Journal to inform the membership of this important Society activity.

### General Information

A pamphlet, readily identified by its blue color, entitled "Fee Schedule and Complete Instructions for Veterans' Administration Fee Designated Physicians" was recently mailed to each member of the Society. Much time and effort can be saved if all doctors become familiar with the instructions contained in this booklet.

Additional fee designated physicians may be appointed at any time. The procedure is not complicated but, being rather closely regulated, must be as follows. The doctor must be a member of the Kansas Medical Society in good standing since this agreement with the Veterans' Administration is made by the medical society. The medical society requires the doctor's signature on a government post card and his request to serve as a general examiner or as a special examiner as defined on Page 7 of the pamphlet. The application is to be mailed to the Executive Office of the Kansas Medical Society, 406 Columbian Building, Topeka, Kansas. This application is then forwarded to the

councilor of the district in which the applicant practices. The application, together with the councilor's recommendation, is then brought to the attention of the Committee on Veterans' Administration affairs. If approved, the name is sent to the Veterans' Administration and a formal application is mailed to the physician. This application comes from the district office at Wichita and must be returned before the Veterans' Administration may pay the doctor for services rendered. While this procedure is in the process of completion the physician might be paid, but that is on a temporary basis.

The physician will receive word from the Medical Service Center when an examination is to be made. Medical examiners are chosen in rotation, taking into account the veteran's residence. The physician's notice to make the examination is his authorization and his assurance that the examination will be paid for.

If a veteran requests treatment, the physician shall then obtain authorization wherever possible before treatment is begun. It should be recalled that for males the condition must be service-connected if the Veterans' Administration may authorize treatment. Note Pages 8 and 9 in the pamphlet for a complete discussion concerning eligibility for care. When hospitalization is authorized, the hospital will also receive authorization at the same time. In cases of medical treatment where authorized, special prescription blanks will be sent to the physician. He may dispense the drugs and receive payment for their cost, or may give the prescription to the veteran who may then have it filled at a drug store. The druggist will then be paid for the cost of the prescription. Authorization for all usual costs relating to the treatment involved are authorized for payment when the treatment is authorized. If exceptional expenses arise in the course of treatment, the Veterans' Administration Medical Service Center should be notified immediately so that authorization can be obtained.

Upon request for authorization for treatment the physician should state whether hospitalization seems to be indicated and, if not, the number of calls that will be required per week as well as the expected length of time the patient will need to be treated. If, in the course of treatment, it becomes necessary to increase this time, additional authorization can be obtained. It is necessary, however, for all authorizations to be specific in the above regard and for that reason the administrator of the Medical Service Center would appreciate obtaining the information from the physician who intends to treat the patient.

### Veterans' Administration Medical Form 2545

Physicians requested to make general examinations to determine disabilities will receive instructions by mail. There will be a Veterans' Administration Form 2639. This is the authorization. It states what services are authorized, the fee that will be paid, and the manner in which the bill for such services shall be submitted.

Enclosed also will be an abstract from the veteran's medical record which is confidential material and must be returned with the completed examination, together with other forms. Examining physicians will find this of great benefit in making examinations since material contained therein is a summary of the patient's past medical history.

Form 2545 must be filled out completely. Note in particular Item 9, which represents the present complaint as made by the patient. His signature is required. Item 29 requests information regarding x-ray examinations. If an x-ray examination is made, the findings should be written. This should be a description of the appearance of the plate. Item 31 is highly important. The examining physician must make a diagnosis on the basis of present findings.

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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154  
*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60

*Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241  
*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592.

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This diagnosis shall be a clear description of the patient's disability, if any, and must be definite. In certain instances physicians have been doubtful about their diagnoses; in other cases they have attempted to suggest possible causes for existing conditions; and in other cases the diagnosis has not been specific enough.

The completed examination is returned to the Veterans' Administration Medical Center, 518 New England Building, Topeka, Kansas, from where it is sent to the regional office. The entire examination is studied by a rating board. Two of the three members on this board are lay persons. This board can judge the veteran's disability only on the basis of the completed examination. It is therefore essential that an accurate picture of existing conditions be given to enable the board to evaluate the extent of disability involved. The examining physician does not need to do this.

The physician, when authorized to make an examination, is also authorized to make any laboratory examinations that are normally required. If additional laboratory tests seem to be indicated or if a special examination is needed, these should be recommended on this form, 2545, or authorization should be obtained to have those tests included.

Accompanying the completed 2545 shall be the physician's statement made in duplicate, of which the first, and only the first, copy shall be signed. Attention is also made to general instructions that are printed on the back of each 2545. These should be read carefully before the examination.

"There are some men who lift the age which they inhabit—till all men walk on higher ground during that lifetime."—Maxwell Anderson.

## COUNTY SOCIETIES

The May meeting of the Cherokee County Medical Society was held at Dr. Joseph W. Spearing's cabin on Spring River. During the program Dr. Spearing reported on the annual session of the Kansas Medical Society and a technicolor film was shown through the courtesy of the Davis and Geck company of Brooklyn. The society will hold no meetings during the summer months.

\* \* \*

The Montgomery County Medical Society has announced the election of the following officers: president, Dr. C. E. Grigsby, Coffeyville; vice president, Dr. J. T. Swanson, Independence; secretary, Dr. E. O. Squire, Coffeyville.

\* \* \*

Dr. C. C. Dennie, Kansas City, Missouri, presented the scientific program at the meeting of the Saline County Medical Society held at the Cafe Casa Bonita, Salina, on May 9.

\* \* \*

Physicians of Winfield were hosts May 16 to members of the Tri-County Medical Society, composed of doctors from Cowley and Sumner counties in Kansas and Kay county in Oklahoma. Sixty physicians took part in the golf match at the Winfield country club during the afternoon, after which there was a dinner and program. Dr. J. P. Berger, Wichita, addressed the group on skin diseases and Dr. Paul M. Vickers, Oklahoma City, spoke on surgery.

\* \* \*

The regular meeting of the Crawford County Medical Society was held April 25 at the Hotel Besse, Pittsburg. Dr. Wallace Green of Kansas City discussed surgical problems and told of the surgical program in Army general hospitals. A musical program was presented by Walter McCray of the KSTC music department.

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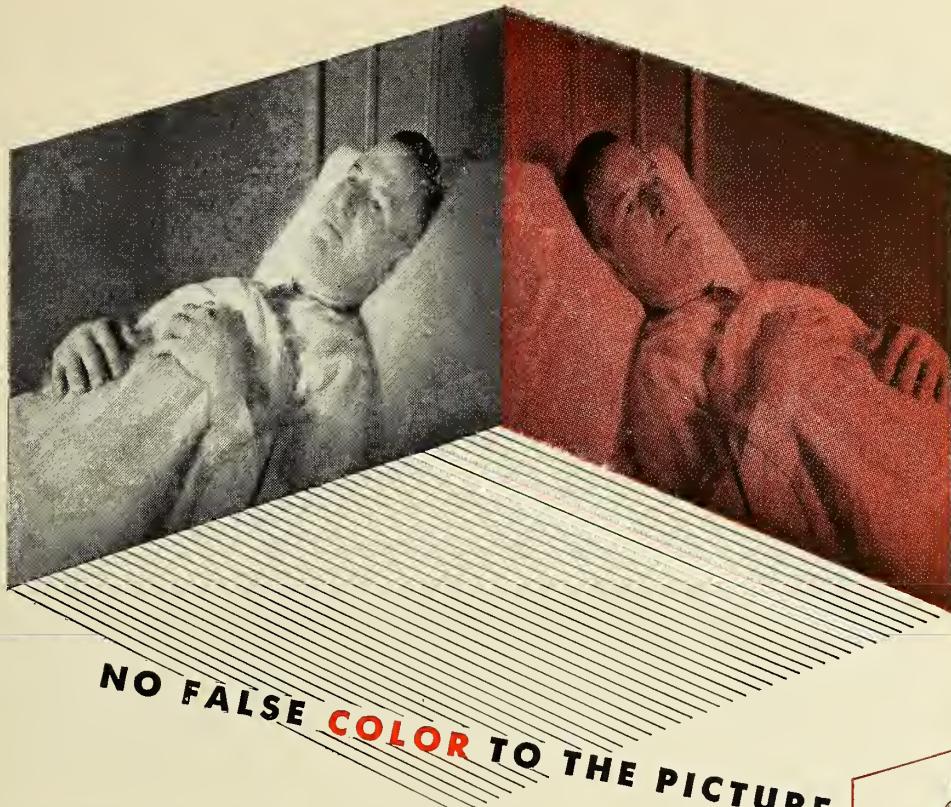
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## MEMBERS

Dr. L. L. Huntley has announced the opening of an office in Washington as soon as his Army discharge is effected. For seven years he was a surgeon in an African mission and during the war he served in the China-Burma area. He formerly practiced in Larned.

\* \* \*

Dr. Thomas J. Sims has re-opened his office in Kansas City for the practice of obstetrics and gynecology after having served for 40 months in the Army. He is associated with Dr. Harold V. Holter, who received his discharge from the Navy in January.

\* \* \*

Dr. L. J. Ruzicka recently opened an office in Belleville. A graduate of Nebraska University Medical School, he has been serving in the armed forces for three years in the Pacific theater.

\* \* \*

Dr. Wayne Bartlett has resumed his practice in Wichita after having served in the Army for three years with the 77th evacuation hospital in the ETO. He held the rank of lieutenant colonel at the time of his discharge.

\* \* \*

Dr. Byron W. Walters, who was recently discharged from the Army after five years' service, has announced the opening of an office in McPherson.

\* \* \*

Dr. John C. Mitchell has re-opened his office in Salina after having served several years in the Army, 16 months overseas in the ETO.

\* \* \*

Dr. Louis N. Speer, who has been serving as a flight surgeon in the 110th reconnaissance squadron in the Pacific area, has opened an office in Ottawa. He is a graduate of Northwestern Medical college with the class of 1940.

\* \* \*

Dr. Preston E. Beauchamp was separated from the Army recently and has returned to his practice at Sterling.

\* \* \*

Dr. Spencer H. Boyd, who has been serving in the Army in the ETO, has been discharged and has resumed his practice in Topeka, specializing in obstetrics.

\* \* \*

Dr. Arthur E. Hertzler, Halstead, who has been practicing for 54 years, announced his retirement recently. For the past 44 years he has headed the staff of the hospital he founded at Halstead.

\* \* \*

Dr. Carl H. Ruff of Elmhurst, Illinois, recently began practice in Clay Center as an associate of Dr. F. R. Croson. Dr. Ruff was released from the Army last November after having served three years, 18 months in the ETO.

\* \* \*

Dr. Schuyler Nichols, who has practiced in Herington for the past 40 years, has announced his retirement from active practice.

\* \* \*

Dr. C. W. Henning has returned to his practice in Ottawa after having spent 40 months in the Army. His associate in practice, Dr. Joseph R. Henning, also served in the Army and returned to civilian life several months ago.

\* \* \*

The Cloud County Medical Society has announced the return to civilian practice of two of its members, Dr. John

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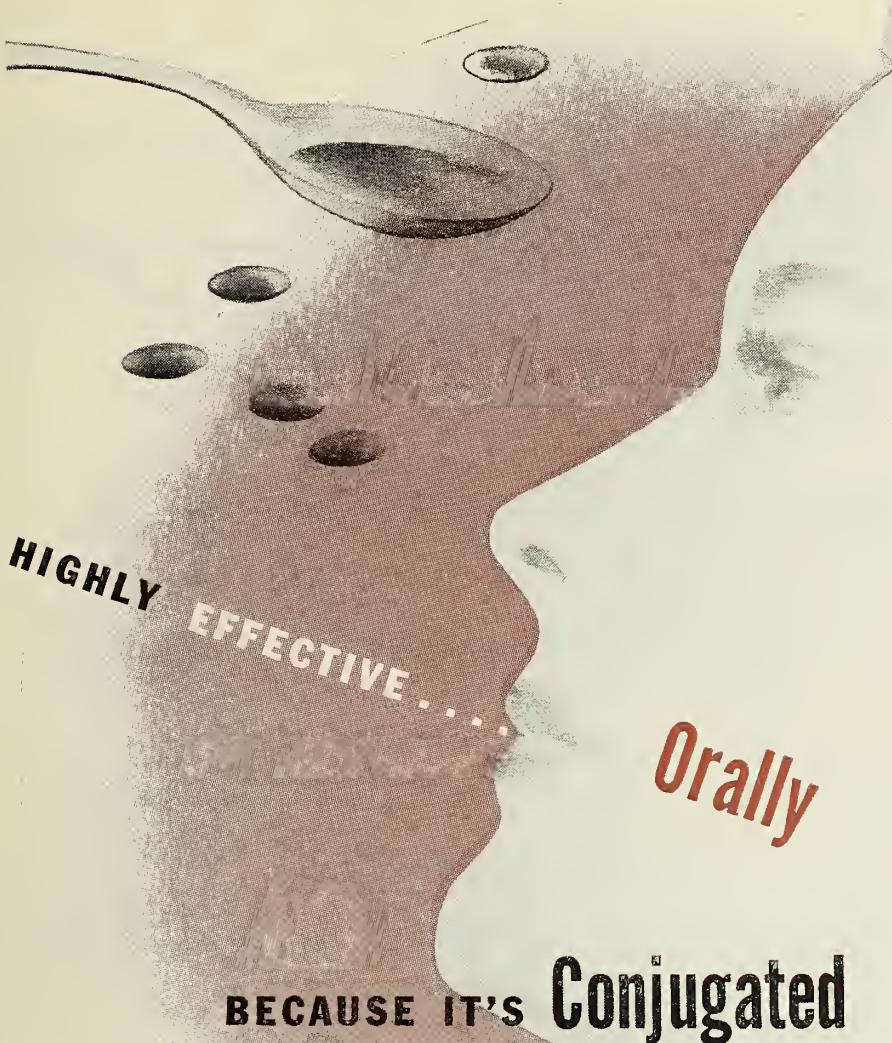
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M. Porter, who has been serving in the Navy, and Dr. H. T. Robertson, who has been in the Army.

\* \* \*

Three members of the Kansas State Board of Health were recently reappointed by Governor Andrew Schoeppel for three-year terms expiring March 27, 1949. The three are Dr. Forrest L. Loveland, Topeka; Dr. Clyde D. Blake, Hays; Dr. G. R. Hastings, Garden City.

Dr. W. J. Stewart, Frankfort, has been appointed health officer for Marshall county and Dr. L. E. Beal, Fredonia, health officer of Wilson county.

\* \* \*

Dr. Philip W. Morgan, who has been serving as a major in the Army medical corps, was released from the service in April and has resumed his practice in Emporia. Dr. Morgan spent 17 months overseas in the ETO.

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*1. Freed, S. C., and Greenhill, J. P. (1941), J. Clin. Endocrinol., 1:983, December.*

*Estrone Aqueous Suspension. 2 mg.*

Dr. Otto F. Prochazka, formerly of Wichita, has opened an office in Liberal. He has been serving in the Army since 1939 and held the rank of major at the time of his discharge.

\* \* \*

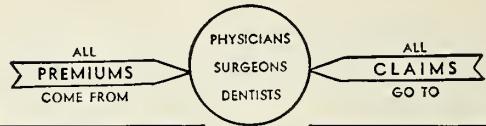
Governor Andrew Schoeppe has announced the re-appointment of two members of the state board of medical registration and examination, Dr. G. R. Dean of McPherson and Dr. C. E. Joss of Topeka. The appointments will expire April 30, 1950.

\* \* \*

Dr. Rodger A. Moon, who has just completed a course in graduate work at Cook County Graduate School of Medicine, Chicago, has announced the opening of an office in Emporia.



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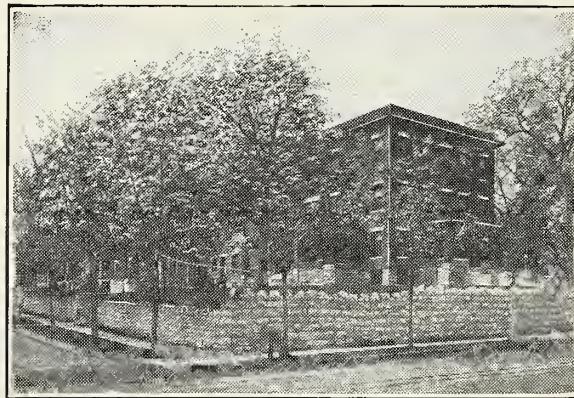
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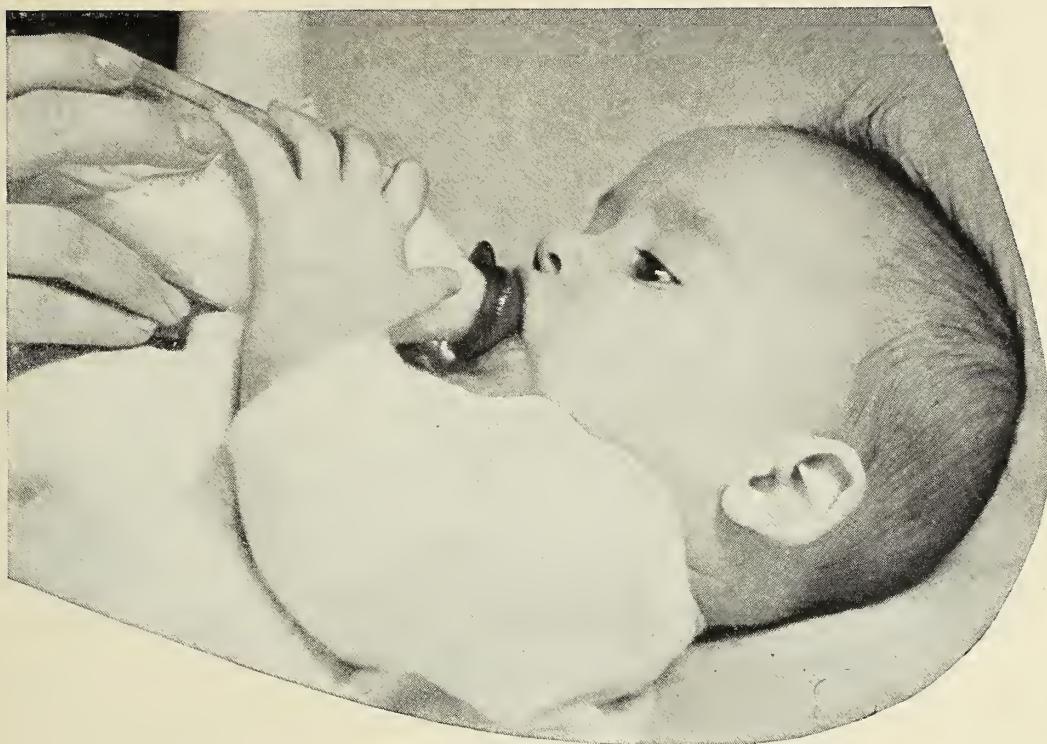
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## ANNOUNCEMENTS

A refresher course in obstetrics and gynecology will be presented by the School of Medicine, University of Kansas, Kansas City, in cooperation with the Kansas Medical Society and the Kansas State Board of Health, from June 17 to 21, inclusive.

The following guest instructors will speak:

Frederick H. Falls, M.D., professor of obstetrics and gynecology, University of Illinois Medical School, Chicago, Illinois.

John W. Harris, M.D., professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison, Wisconsin.

William G. Mengert, M.D., professor of obstetrics and gynecology, Southwestern Medical College, Dallas, Texas. John H. Moore, M.D., professor of obstetrics and gynecology, University of North Dakota Medical School, Grand Forks, North Dakota.

Grandison D. Royston, M.D., clinical professor of obstetrics and gynecology, Washington University, St. Louis, Missouri.

\* \* \*

A three-day assembly of the United States Chapter, International College of Surgeons, will be held in Detroit, October 21, 22 and 23. In addition to prominent surgeons in the United States the list of speakers includes persons from London, Peru, Argentina and Mexico. Detailed information and programs may be secured from L. J. Gariepy, M.D., 16401 Grand River Avenue, Detroit 27, Michigan.

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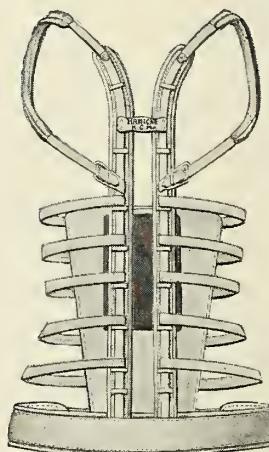
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Volume XLVII

JULY, 1946

No. 7

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## CALCIFICATION OF THE PLEURA

C. F. Taylor, M.D.

Norton, Kansas

and

L. K. Chont, M.D.

Winfield, Kansas

Calcification of the pleura is a comparatively rare pathological condition. Its incidence is almost identical in the statistical reports of five large institutions (two American and three German) dealing primarily with diseases of the chest. They record 53 cases of pleural calcification among 31,160 patients examined with roentgen rays. Their percentage ranges from 0.12 to 0.20 with an average of 0.17 per cent. Ulrich's statistic is the highest recorded in the literature. He found 16 cases among 1,845 patients (0.86 per cent) in a period of thirteen months. Probably the frequency of thoracic injuries of World War I is responsible for the high percentage of pleural calcification in Ulrich's report. Many individual cases were recorded in the belligerent countries of World War I due to gunshot and bayonet wounds. Probably we can expect an increase in this condition among veterans of World War II who have suffered from hemothorax due to wounds and injuries of the thoracic cage.

In our own series we found nine cases of calcified pleura among 6,301 patients (0.14 per cent) examined with roentgen rays for diseases of the chest in a period of seven and one-half years.

The great majority of cases are discovered in the second half of the life span. Probably, Salter's case occurring in a six-year-old boy and Goulliond's 81-year-old patient are the extremes in age incidence. Brauer reported a case occurring in a child of 12 and one-half years following pleurisy at the age of 18 months. In our series the youngest individual was 27 years old and the oldest 70 years of age. At the time of discovery of pleural calcification the average age was 51.6 years among our patients; 66.6 per cent of our cases occurred above 50 years of age and only 22.2 per cent under the age of 40.

This condition is primarily a disease of the male sex. According to Pritchard, two-thirds of the cases recorded occurred in men. In Head's series, collected from the literature, 47 of the 55 cases were males (85.4 per cent). The prevalence of the males was even more pronounced in our own series, eight of our nine patients were males (89 per cent).

The etiology of pleural calcification was discussed by several authors. Tuberculosis was declared as a causative factor by many and denounced by about the same number of investigators. Pritchard believes that the tubercle bacillus is practically never responsible for pleural calcification. Endres, Ulrich, and practically all of the older writers on this subject are of the same opinion. Lippmann reported a case observed four months after pneumonia. Head states that tuberculous pleurisy and traumatic hemothorax account for practically all cases of pleural calcification. He believes that the calcium is deposited in the intrapleural space by dialysis from the pleural exudate. He supports his belief by the fact that the calcium deposits are found upon the surface of the pleura, loosely attached to the tissues and they are easily removable by simple manipulation. He quotes Pinner and Moerke whose investigation disclosed that tuberculous pleural effusion has the same composition as blood serum. According to Head this fact suggests a similar biochemical process in the formation of pleural calcification following hemothorax as in tuberculous pleural effusion. Some authors do not support Head's theory of dialysation of calcium salts from the extravasation in case of hemothorax, but believe that the pleural calcification results from organization and hyalinization of the blood in the pleural space with secondary calcium deposits. Furthermore, Head applies the theory of Andrews, Schoenheimer and Hrdina on

the mechanism of gallstone formation to the process of pleural calcification to prove his hypothesis of dialysis. Andrews and his co-workers have shown that in the presence of infection the epithelium of the gall bladder is often altered, then it acts as a dialyzing membrane and filters out and deposits cholesterol, forming gallstones. Head assumes that certain infections might alter the pleura so that it acts as a dialyzing membrane and retains the calcium salts from the pleural effusion as the fluid absorbs.

Wessler and Jaches, likewise, believe in the tuberculous origin of pleural calcification and state that, "among the rarer forms of pleural tuberculosis are localized deposits which, like the lesions in the lung, may undergo caseation and calcification." They believe that "bizarre" forms of pleural calcification (like our case No. 1) suggest a bovine infection. One of their cases of acute miliary tuberculosis showed tubercles on the pleura, while the lungs themselves showed no evidence of miliary tuberculosis. Darbois, also, is of the opinion that tuberculosis is the most common cause of pleural calcification.

Apitz and Frishbier hold the opinion that a calcium diathesis exists in those individuals having pleural calcification and they are habitually inclined to have calcinosis. No other investigators found an increase of calcium in the blood or of the calcium metabolism, and this hypothesis was refuted by most workers on this subject. In our own series no other abnormal calcium deposits were found save those of the pleura.

In our series five patients (55.5 per cent) showed definite signs of tuberculosis on roentgenogram, three of which (37.5 per cent) had positive sputum on admission. One of the patients having tuberculosis, suffered from severe chest injury 62 years prior to admission, and another had pneumonia ten years before entering our hospital. One had a chest injury, with hemoptysis, twenty years prior to hospitalization and pneumonia antedating by 51 years our examination, but no evidence of pulmonary tuberculosis was seen roentgenologically. Another had a chest injury from an automobile accident with long lasting chest pain ten years prior to our roentgen examination, but no history of any pulmonary disease nor sign of tuberculosis on the roentgenogram. One of our patients had no history of injury or any previous pulmonary disease. She was referred to us because of considerable loss of weight and strength following childbirth. Judging from her stereo-roentgenogram, she has had a circumscribed area of infection of the pleura at the left base (probably a tuberculoma) which healed completely with secondary calcium deposits. One patient (case No.

9) had tuberculous pleural effusion seven years prior to our examination.

It is known that calcification occurs often in tumors in the form of inorganic calcium salt deposits in necrotic areas, and in tissues undergoing hyaline degeneration. It also occurs in the lungs and practically in all other organs as part of the reparative process following caseation, hemorrhage and necrosis due to infection or trauma. In our series we observed pleural calcification following traumatic hemothorax as well as after tuberculous and non-tuberculous pleural effusion. Some cases were associated with pulmonary tuberculosis and others showed not even a trace of pulmonary phthisis.

On the basis of our own observation, we are of the opinion that calcification of the pleura may be caused by any infection or trauma where the tissue damage is sufficient to be followed by hyaline degeneration, necrosis or fibrosis. In other words, pleural calcification is the end result either of tissue repair following degeneration, necrosis and fibrosis, or of incomplete absorption of pleural effusion, tuberculous or non-tuberculous, or organization of pleural hemorrhage.

The gross pathology of pleural calcification consists of a false calcified fibrous membrane upon the surface of either pleura so loosely attached to the tissues that in the great majority of the cases it is easily removable by manipulation. It varies in size and thickness considerably, from small, thin calcium plaques, to extensive, one to two cm. thick lime shells encasing almost the entire lung or covering the entire parietal pleura. The calcified membrane may pierce the pleura and enter into the interlobular fissures and sometimes even into the lung tissue as small thin calcium needles. Hill reported a case where the calcifications varied from one to two cm. in thickness, covered the entire left parietal pleura and was adhered to and had destroyed the eighth to tenth ribs. In our series we had only one autopsy (case No. 5); on opening the pleural cavity both lungs were quite bound down with fibrous adhesions. There was an area of rather marked pleural thickening at the left base measuring about five by ten cm., composed of thick, dense fibrous tissue. There were numerous small areas of calcified plaques scattered throughout both parietal pleura, most marked on the pleural thickening at the left base.

The microscopic picture of pleural calcification is similar to that of a dense cartilaginous tissue. It is composed of abundant collagenous fibers but the cellular and vascular elements are scarce. The calcium is scattered throughout the field in the form of irregular plaques and bands.

The clinical symptoms as well as the physical

signs vary according to the extent of the lesion. Moderate or even extensive lesions (like our case No. 1), may be symptomless if uncomplicated. On the other hand, if the calcification is thick and retracts the thoracic organs or cage, a less extensive one (like our case No. 6) might produce symptoms. The symptoms are usually "pleurisy pain," dyspnea, and cough. As a rule, the symptoms are mild and vague. According to Head, about 50 per cent of the uncomplicated cases are symptomless. The only complication encountered in the literature is infection of the pleural cavity with or without a bronchial communication due to the foreign body action of the pneumoliths.

The physical signs, if any, are those of pleural effusion, namely diminished fremitus, percussion, and breath sounds and in certain cases, retraction of the thoracic cage with decreased or absent respiratory movements.

The pleural calcification on the roentgenogram is characteristic, it appears like flat plaques of calcium density forming an irregular network. The lesion is usually located at the lateral aspect of the lung. In advanced cases it envelops the lateral part of the lung as a perforated shell. Retraction of the lung from the chest wall at the site of an advanced lesion is common, it occurred in 4 of our 9 cases (44.5 per cent).

#### CASE REPORTS

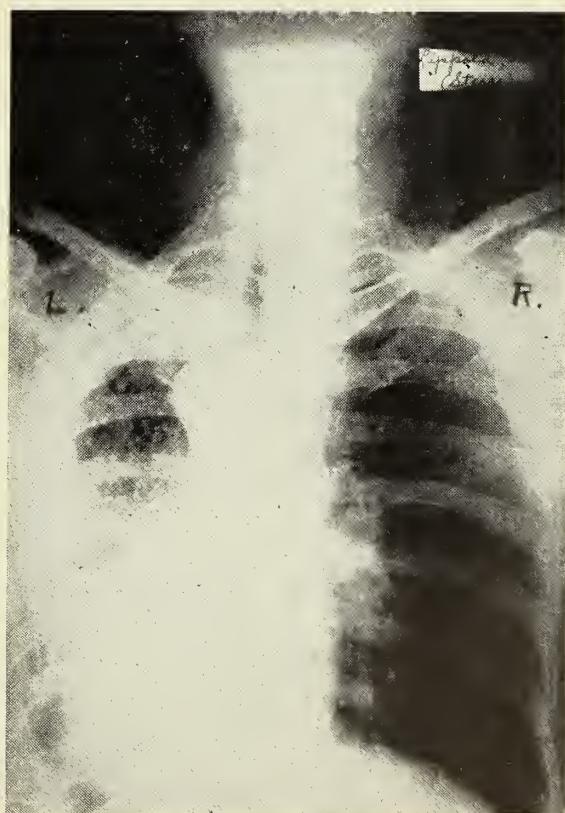
Case I. J. S., white male, farmer, aged 70, was admitted with chest pain, cough and high temperature of a few days duration. Roentgenogram of chest showed soft spotty infiltration at both bases, an old healed tuberculous lesion at right apex with pleural thickening, and an extensive fine network of calcified plaques occupying two-thirds of right, and lower one-half of left lung fields. Roentgen diagnosis: Bronchopneumonia, old healed tuberculosis of right apex and bilateral calcification of pleura. Clinical and laboratory findings were those of a typical bronchopneumonia. Sputum examinations (smear and culture) were negative. Patient made an uneventful recovery under routine treatment. On close questioning after radiograph was seen, he admitted that horse stepped on his chest when eight years old and he was ill for several months; no radiograph of his chest ever was made prior to our examination.

Case II. F. L., white male, farmer, aged 63, was admitted with dyspnea and moderate chest pain. He had pneumonia of right lung when fourteen years old and had hemoptysis for a few weeks twenty years ago when a cow struck his chest. Stereo-roentgenogram of chest showed an extensive, thick irregularly confluent calcium deposit enveloping entire posterior and lateral surface of left lung, like a perforated shell. Lung was retracted from apex and

lateral chest wall. Right lung was essentially negative. Repeated sputum examination (smear and culture) was negative for tuberculosis. Physical examination revealed a dullness on percussion and diminished breath sounds on auscultation over posterior and lateral aspect of left lung. Patient improved considerably under supportive and symptomatic treatment.

Case III. Wm. H. S., white male, aged 63, was admitted with hemoptysis, fever and weakness. Roentgen examination of chest showed a chronic fibrous tuberculosis with cavity formation involving right apex and entire upper half of left lung. There was a moderate retraction of right base with pleural adhesion and a fine network of calcified plaques at right base. Sputum examination was strongly positive for tuberculosis. There was no history of chest injury but patient had a pleurisy, most likely tuberculous in origin, twelve years prior to our admission.

Case IV. E. H., white male, aged 52, was admitted with cough, moderate chest pain and weight loss. Radiograph of chest showed a healed minimal tuberculosis of left apex, and an extensive network of calcified plaques at left base measuring 8 x 10 cm. in diameter. Pleura was thickened and left lung appeared to be retracted from thoracic wall at left base. Repeated sputum examinations were negative.



CASE II. Note irregular calcium deposits along left lateral chest wall enveloping lateral surface of left lung. Lung retracted from apex and lateral chest wall.

for tuberculosis. Patient improved considerably under supportive and symptomatic treatment.

Case V. W. R. L., white male, aged 40, was admitted with history of severe cough, hemoptysis, weight loss and fever. Chest roentgenogram showed advanced tuberculosis involving both upper lung fields with multiple cavity formation. Small calcified plaques were scattered and grouped throughout both upper lung fields and formed a confluent network at left base, measuring 3 x 5 cm. in diameter. Pleura was thickened and lung appeared retracted from thoracic wall at left base. Sputum was strongly positive for tuberculosis. Patient died shortly after admission and an autopsy was performed, which confirmed roentgen diagnosis.

Case VI. D. L., white male, a physician, aged 60, had a car accident ten years prior to our examination, which resulted in a long lasting chest pain. Four to five years after accident chest pain ceased and patient has been symptom free since. Recently he developed a cold with a severe cough. We x-rayed his chest to rule out a pneumonia. Radiograph revealed a fine network of calcified plaques at left base measuring 4 x 9 cm. in diameter. Thoracic cage was moderately retracted at left base. Remaining chest was essentially negative.

Case VII. C. H., white female, a housewife, aged 27, was seen at outpatient department for weakness and weight loss. Radiograph of chest showed a round group of calcified plaques at left base measuring 25 x 25 mm. Remaining chest was essentially negative. Sputum examination for tuberculosis was negative. There was no history of chest injury, pneumonia or pleural effusion. Supportive therapy was outlined.

Case VIII. G. W. N., white male, aged 41, was admitted to the hospital with history of weight loss, night sweats, weakness and copious productive cough. Radiograph of chest showed a fibrous tuberculous lesion with a small cavity at right apex. There was an irregular, partly confluent, group of calcified plaques at right base measuring 5 x 10 cm. in diameter. Sputum examination was positive for tuberculosis. There was no history of chest injury,

pleural effusion or pneumonia. He improved considerably under conservative treatment.

Case IX. F. T., white male, a farmer, aged 39, was seen in outpatient department for a check up. Seven years prior to our examination, while serving with the U. S. Marine Corps, he developed a pleural effusion in his right chest. He was sent to a government hospital where tuberculosis bacilli were found in the pleural fluid. He recovered and was discharged. At the time of our examination he was well nourished, his only complaint was that he got tired easily. Roentgenogram of chest showed a pleural thickening and adhesions at right base with retraction of thoracic wall. There was an irregular group of calcified plaques at right base. Remaining chest was essentially negative. Supportive treatment was outlined. Unfortunately there was no other radiograph of his chest taken in the seven years interval.

#### SUMMARY

1. Nine cases of pleural calcification have been reported, one of them with autopsy findings.

2. Pleural calcification is the end result either of tissue repair following degeneration, necrosis or fibrosis, or of incomplete absorption of pleural effusion or organization of hemothorax.

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Specialists in physical medicine are now riding on the wave of public recognition after years of faithful pioneering. The war has given them added opportunity and recognition. Their greatest danger will be that of sacrificing excellence and quality to emergency and quantity. This they should not do and need not do. They have a long past and will have a long and distinguished future if they follow the road, the narrow road, of assiduous study, patient research and genuine cooperation with those in other fields of medicine and preserve the spirit of service, which is an essential to greatness in any realm.—Ernest J. Jaqua, Ph.D., in Archives of Physical Medicine.

The present high cost of sickness had its beginning in the latter part of the last century, and is due almost entirely to the rapid advances of medical science and the general acceptance of the community hospital instead of the home as the best place for the care of the sick. That both these trends are sound is shown by the rapid growth of specialization in medicine and the increasing use of hospital service by the well-to-do, the patient of moderate means and the practitioner of medicine.—George W. Holmes, M.D., in the New England Journal of Medicine, May 17, 1945.

# THE COMPARATIVE VALUE OF PENTOTHAL SODIUM, CURARE, AND MAGNESIUM SULFATE FOR THE MODIFICATION OF METRAZOL CONVULSIONS

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When convulsant shock therapy first came into prominence in the treatment of mental disorders, it became apparent that induced convulsions were frequently so violent as to cause fractures and dislocations of considerable magnitude. The use of convulsant therapy was seriously retarded for this reason until some method of "softening" the convulsions became available for general use. It was, therefore, a notable advance when curare was introduced by Bennett for the purpose of modifying induced convulsions.

Curare has the disadvantage of not being a pure chemical, and the standardization of the preparation is not adequate to eliminate uncertainty of effect. There has been a wide search for other anticonvulsants, but none of these have taken the place of the unpredictable and variable curare.

Yaskin seemed to have found the ideal solution when he introduced magnesium sulfate as an anticonvulsant. He was searching for a drug that would act at the neuromuscular locus; that had a high margin of safety, and that had a simple specific antidote. He believed that magnesium sulfate, which has a curare-like effect at the myoneural junction, would meet these requirements. He injected 24 to 30 cc. of 25 per cent aqueous solution of magnesium sulfate intravenously, as rapidly as possible. A dosage of 100 to 120 mg. per kg. was necessary to produce the desired paresis in human beings. His subjects experienced a feeling of heat, and they manifested a flushing of the face and neck, diaphoresis, bilateral ptosis, weakness of the neck muscles and slurring of speech.

In Yankin's experience a maximal paresis was reached in two to three minutes at which time the estimated convulsive dose of metrazol was given rapidly by vein. Because the effect of both the magnesium sulfate and metrazol lasted only three to six minutes, time was of importance in the procedure. In his cases he found adequate softening of the convolution, and there were no side actions of any magnitude.

Later, Rosenbaum and Lipton reported the death of a patient during the use of magnesium sulfate intravenously. They had no proof that the patient died a cardiac death, but they felt certain that the

patient suffered a sudden cardiac arrest from direct action of magnesium sulfate upon the myocardium. Since this report was published magnesium sulfate has fallen into disuse as an anticonvulsant.

Miller and VanDellen, in studying the electrocardiographic changes following the intravenous administration of magnesium sulfate, have noted an early acceleration of the pulse followed by a delay of auriculoventricular and intraventricular conduction and increased excursion of all electrocardiographic complexes. These effects persisted for an hour or so. In their work, however, they demonstrated that respiration stopped before cardiac activity, and that cardiac arrest was preceded by bradycardia without arrhythmia. This work is in accord with the findings of V. G. Haury who concluded that the magnesium ion acts peripherally on the cardiovascular system. Bernstein and Simkins also observed minor T-wave and QRS-complex changes in the electrocardiogram of patients injected with magnesium sulfate, but concluded that intravenous magnesium sulfate exerted no deleterious effect on the human heart.

Smith, Winkler, and Haus described the toxic effects of magnesium sulfate in increasing doses on dogs and cats. They noted that amounts sufficient to produce respiratory arrest did not result in cardiac standstill if artificial respiration was administered.

Other anticonvulsants have also been investigated in a preliminary manner. Merritt and Putnam described an apparatus for determining the threshold to electric fits. They used this apparatus in testing a series of anticonvulsants and studied changes of convulsant thresholds. They also investigated the relationship between soporific effect and anticonvulsant effect. They reported on the effects of alcohol, amyta, pentobarbital, phenobarbital, diphenylhydantoin and other agents. Because their object was to determine the elevation of convulsant thresholds, they did not investigate actual softening of convulsions as applicable in clinical psychiatry.

Tainter and his associates have also studied this problem. They found that barbital compounds and dilantin raised the threshold in proportion to the dose. In their work the anticonvulsant was administered by hypodermic injection 30 minutes before the determination of the convulsive threshold. This does not correspond to the methods that have been

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used clinically for softening convulsions by any drug, but the results are of great interest. Dilantin was shown to be a very weak anticonvulsant, and sodium bromide raised the threshold only moderately. Chloral hydrate had little effect in sedative or hypnotic doses, but sub-anesthetic amounts did significantly raise the threshold. Alcohol and paraldehyde raised the threshold to a very marked degree. It is significant to note that morphine did not change the threshold at all.

Impastato and his co-workers reviewed the subject of anticonvulsants in shock therapy, and concluded that curare had many disadvantages. These include the disagreeable sensation of being paralyzed, prolonged apnea, and the unpredictable effect of the drug. They point out that in eight deaths caused directly by electrofits less than half the cases received curare, but half of the deaths were in patients who had been curarized. This indicated to them that curare was probably responsible for some of the deaths.

These authors decided to use sodium amytal as a modifying agent for the convulsant therapy. For the first treatment, the patient's convulsive threshold was determined in the usual manner. At the subsequent treatment the patient was given 0.3 of a gram of a fresh solution of sodium amytal intravenously one or two minutes before the fit. This caused drowsiness and nystagmus. If the patient fell asleep the dose was reduced before the next treatment. During the two minutes interval between the injection of the sodium amytal and the administration of the convulsion, they observed whether the patient "cleared" or gained any insight, and on this basis a note was made as to the probable prognosis.

After the administration of the convulsant amount of electric current the response of the patient was noted. These reactions were found to vary from *petit mal* to *grand mal* type seizures. If the resulting convulsion was too mild for therapeutic effect more current was employed for the next treatment. They found that modified *grand mal* seizures and closely related phenomena as well as delayed *grand mal* seizures, resulting in fairly severe but not traumatic convulsions, were therapeutically effective. An unmodified *grand mal* seizure was considered to be too severe and the current was reduced for the next treatment. In conclusion they note that the therapeutic results are equal to those of the unmodified convulsions.

#### METHOD

In our experiments curare, magnesium sulfate, and pentothal sodium were used. This is a preliminary report.

In order to test the various drugs for their anti-convulsant effects it was considered desirable to have

a standard convulsant agent and a standardized technique. In our work fairly large dogs were used, and metrazol was administered intravenously as a convulsant agent. In using dogs of different sizes and varying amounts of metrazol it was determined that 0.3 cc. per kg. of the commercial solution (100 mg. per cc.) would uniformly produce severe and typical convulsions characterized by apnea, marked tonic and clonic activity with salivation, pupil dilatation, and involuntary urination. The convulsant dose of metrazol was found to vary widely, most dogs showing typical seizures after the administration of 0.15 cc. of metrazol per kg. All of the animals were able to withstand 0.6 cc. per kg. without serious effects.

Because it is well known that intravenous metrazol varies in its convulsant effectiveness, depending on the rapidity with which the drug is given, a standard technique for the intravenous administration was adopted whereby the drug was injected within 10 seconds.

After standardizing the technique of producing convulsions, we tested varying doses of the anti-convulsant drugs by injecting them at different intervals preceding the administration of the metrazol.

#### RESULTS

##### A. Curare (Intocostrin).

Curare was given intravenously, followed at the height of paresis (two minutes) by the convulsant dose of metrazol. A dosage of one unit per kg. was found to modify the convulsion somewhat, both as to intensity and duration. The modifying effect was, however, incomplete as indicated by the duration of the apnea (50 to 60 seconds). The convulsive seizures, although slightly less strong than the unmodified ones, lasted from one and a half to four minutes.

The convulsions were of a peculiar character. They were mild and remittent or intermittent. Just when an animal seemed to be recovering from one convulsion another would develop. This led us to try a larger dose of curare in hopes of shortening the duration of convulsive activity as well as rendering the seizure less violent. Efforts in this direction were fruitless. A dose of 1.5 units per kg. seemed to be little more effective than the dose of one unit per kg., and the recovery period was prolonged considerably. One animal was given two units per kg. This dog had mild convulsions for four minutes and finally died a respiratory death, in spite of the administration of one cc. of neostigmine (1:2,000) intravenously.

##### B. Magnesium Sulfate.

Preliminary work with magnesium sulfate indicated that a larger dosage would be required to produce paresis in dogs than in human beings. In our

experience 250 mg. per kg. produced a paresis comparable to that described in patients. This dosage caused a generalized decrease in muscle tonus, decrease in patellar reflex, marked weakness of the neck muscles, and diminished thoracic respiration. The peak of paresis was reached in approximately two minutes, and the animals showed nearly complete recovery in seven to fifteen minutes.

The magnesium sulfate was given into the femoral vein, and the total dosage was administered in 30 to 60 seconds. One and a half minutes later the convulsant dose of metrazol was administered. The convulsions were all typical, but they were not so violent as the unmodified ones, and the period of apnea was reduced by 50 per cent (i.e. to 30 or 40 seconds). The recovery period was not materially shortened. Most of the animals were only partially recovered in fifteen minutes.

The results with reference to modifying metrazol convulsions were quite satisfactory except that one animal died unexpectedly. Ten seconds after the completion of the administration of the magnesium sulfate (250 mg. per kg.) there was a sudden cessation of the cardiac impulse. Prompt artificial respiration was of no avail. We had no choice but to consider this a cardiac death.

#### C. Pentothal Sodium.

Various doses of pentothal sodium were employed. Two to five mg. per kg., intravenously, was sufficient to modify the convulsions without producing notable paresis or hypnosis of the animals. By simple trial a dosage of three mg. per kg. was found to be the most dependable.

Using this amount of pentothal routinely and the "standard" convulsant dose of metrazol, we injected the two drugs at various intervals. Because of the fact that the latent period of both drugs is very short, it was decided to try simultaneous administration. Interestingly enough the solutions were found to mix well, and the results in modifying the convulsions were most gratifying.

The convulsions were, with very few exceptions, typical generalized tonic and clonic seizures associated with apnea and, frequently, with loss of sphincter control. The period of apnea was reduced to about 30 seconds, and the convulsions lasted only 45 to 75 seconds.

The convulsive seizures were followed by a short period of recovery. Most animals were walking within three minutes and, although they seemed to be euphoric, they gave little evidence of incoordination.

In no case did any unfavorable reaction follow the administration of pentothal or the mixture of pentothal and metrazol.

#### SUMMARY AND CONCLUSIONS

The desirability of a stable and safe agent for modifying therapeutic convulsions has long been recognized, but comparatively little work has been reported in this field. Curare has received the most attention. It is not altogether dependable. Some observers even consider it to be unsafe.

Magnesium sulfate and sodium amytal have been shown to be useful in a few cases. According to most workers magnesium sulfate is too dangerous for routine use. Our experiments, although of a preliminary nature, indicate that magnesium sulfate might be a most desirable "softening agent" were it not for the possibility of sudden cardiac arrest.

Pentothal sodium is superior to magnesium sulfate, and far superior to curare as a modifying agent for metrazol convulsions. It has the added advantage of few toxic possibilities.

Additional work is needed to demonstrate the effectiveness of pentothal in modifying electrofits. The question of its applicability in the treatment of mental disorders is not settled, but the work on sodium amytal justifies the belief that pentothal may be clinically useful.

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## THE EFFECT OF VARIOUS SUTURE MATERIALS IN WOUND HEALING\*

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The relative advantages of cotton, catgut and stainless steel wire suture materials are now becoming well recognized. We wish to outline the advantages, disadvantages and proper technique for the use of each of these materials. Some recently reported series of cases dealing with the effect of various suture materials on wound infection and healing have been incomplete in detail. Frequently the size of the catgut used has not been stated, or has varied. We will review our recent experience in a well controlled series of 586 consecutive cases.

These 586 operative wounds have all been closed by one of us under practically constant operating conditions. The time period extends through months of the year when upper respiratory infections were prevalent or infrequent among operating room personnel. The length of the series is limited to meet these conditions. The differences noted between catgut and wire are statistically significant. Cotton was infrequently used and is included in the tabulation only because the cases are consecutive.

The suture sizes have been constant. All cases had vertically mattress skin sutures of number 35 wire. This limits our consideration to the deeper tissues and practically eliminates capillarity as a possible factor in wound infection. Wounds closed with wire had number 32 or 35 as interrupted sutures in the peritoneum and posterior rectus sheath, number 32 in the anterior rectus sheath, number 35 for subcutaneous ties, and number 30 tension sutures in the few instances where these were employed. Number 32 was used for the repair of hernias. Wire must always be placed as an interrupted suture to avoid kinking and breaking of the suture material.

The catgut used was all 0 chromic in the peritoneum and fascial layers. It was always placed as a continuous suture in the peritoneum and posterior rectus sheath. In the anterior rectus sheath and external oblique aponeurosis interrupted sutures were employed in approximately half the cases. Plain 0 was used for subcutaneous ties.

The cotton was all number 40 interrupted.

Regardless of the type of suture material used, a systematic effort was made to minimize tissue damage by employing sharp dissection and small hemostats which grasp little tissue to avoid tying masses of fat or muscle with the vessels. Hemostats on subcutaneous bleeders were left in place during the procedures. This enabled us to use very few ties since

most vessels no longer bleed after held for thirty minutes. Warm sponges and pressure dressings also reduce the quantity of suture material necessary for ties. We have seen a few hematomas, but these are certainly an easier problem than the painful, indurated and frequently infected wounds in which many ties have strangulated much tissue. Fluid, electrolyte, protein and vitamin needs have been carefully provided.

Where drains were used they were brought out through stab wounds well removed from the incision except in a few instances where work was done in the female pelvis.

Moderately early mobilization of the patients has been carried out as follows:

thyroidectomy	
mastectomy	1st-3rd day
appendectomy	
gastric resection	
colon resection	
cholecystectomy	3rd day
perforated ulcer	
hysterectomy	
herniorrhaphy	1st to 6th day depending on the type of hernia

Several years ago we had some difficulty in effecting early mobilization of the patient. They were reluctant to get up because of discomfort in their wounds. Since changing to the routine use of anatomically sound transverse incisions we have had no complaint. These incisions are practically painless especially when wire is used for their closure. This materially reduces the post-operative complication of atelectasis as the patient no longer suffers pain from deep breathing or coughing. Post-operative thrombosis of the deep vessels of the legs is likewise reduced by early mobilization. It is frequently difficult to close the peritoneum and posterior rectus sheath with interrupted sutures in the vertical upper abdominal wound. When the structures are divided transversely in the direction of their fibers, interrupted sutures are easily placed.

No sulfonamide drugs or penicillin were used in any of the wounds. All wounds which were obviously grossly contaminated and about 50 per cent of those thought to be possibly contaminated were mechanically cleansed by abundant irrigation with normal saline solution. Three years ago we abandoned the local use of sulfonamides in favor of the

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TABLE I

Suture Materials	Total Cases	Wound Complications	Wound Infections
Wire	305	14 (4.5%)	6 (1.9%)
Catgut	216	32 (14.7%)	32 (14.7%)
Cotton	27	2 (7.4%)	2 (7.4%)
Cotton and Catgut	38	6 (15.8%)	6 (15.8%)
Totals	586	54 (9.1%)	46 (7.8%)

irrigations, and since doing so we have had fewer infections and serum accumulations.

The conventional skin towels were used in the catgut cases. They were never employed when using wire because we knew from previous experience that there was little to fear of wound infection in wounds closed with wire. The towels may give a superficial appearance of neatness and good order but they are cumbersome, time consuming and unnecessary.

The wounds are classified as clean, potentially contaminated and contaminated. Unfortunately, it was not feasible to make cultures at the time of operation so our distinction between clean and potentially contaminated wounds is arbitrary. Clean wounds were those in which we saw no obvious opportunity for soiling. Potentially contaminated were those in which open anastomoses were carried out or purulent exudate encountered without actual visible soiling. Those included as contaminated had gross macroscopic soiling with pus, accidental spilling of colon content, or were wounds for the repair of fecal fistulae.

The cases operated were the usual run of major general surgical procedures including hernia repair, appendectomy, cholecystectomy, gastric resection, colon resection, hysterectomy, salpingectomy, radical mastectomy, neoprectomy, hydrocelectomy, thyroidectomy, amputation of leg, lumbar sympathectomy, closures of colostomies and fecal fistulae of other types.

Of the 586 wounds, 305 were closed with wire, 216 with catgut, 27 with cotton, and in 38 both cotton and catgut were used. The latter were hernias in which cotton was used to approximate the transversalis fascia and conjoined tendon to the ligaments of Cooper and Poupart and catgut to close the external oblique aponeurosis. Catgut was used for subcutaneous ties in these cases also.

Four hundred and seventy-seven wounds were considered clean, 70 possibly contaminated, and in 39

cases we were certain that the wound had been contaminated at the time of operation.

The low incidence of A complications we attribute to the use of wire for skin suture in all cases. There is no capillarity. One sees practically no reaction around these sutures if they are not too tightly tied. They are removed with a minimum of discomfort since tissues and exudate do not adhere to the material.

The eight miscellaneous complications in wire sutured wounds include six hematomas and two intra-abdominal accumulations which drained and healed without evidence of infection in the wounds. Several complications with catgut were primarily hematomas, but these became infected.

Included among the surely contaminated wire wounds which healed without complication were four through which fecal fistulae were repaired. The six wire wounds which became infected include two cases where large intraperitoneal abscesses were encountered. One was an elderly lady with inoperable carcinoma of the hepatic flexure of the colon who underwent open ileocolostomy and gastroenteros-

TABLE II

Wound at Operation	Suture Material	Un-complicated	Wound Complications			
			A	B	C	Mis.
Clean 477	Wire 227	222	0	0	0	5
	Catgut 186	169	4	10	3	0
	Cotton 26	24	1	0	1	0
	Cotton & Catgut 38	32	1	3	2	0
Possibly Contaminated 70	Wire 51	47	0	1	0	3
	Catgut 18	13	1	3	1	0
	Cotton 1	1	0	0	0	0
	Cotton & Catgut 0	0	0	0	0	0
	Wire 27	22	0	2	3	0
Contaminated 39	Catgut 12	2	2	4	4	0
	Cotton 0	0	0	0	0	0
	Cotton & Catgut 0	0	0	0	0	0
	Total	586	532	9	23	14

Wound complications are classified as A, B, C, and miscellaneous.

A. Simple stitch abscess not prolonging hospitalization.

B. Pus accumulation in subcutaneous tissues not necessarily prolonging hospitalization or morbidity.

C. Involvement of deeper structures with sloughing of the fascia and prolonging disability.

Miscellaneous. Six hematomas which drained without infection and two cases in which intra-abdominal accumulations drained out through the wounds without primary or secondary infection.

tomy with gross soiling of the operative incision. Two were cases in which ruptured appendices were found and the other was a case of acute gangrenous cholecystitis considered possibly contaminated and developed a B complication.

It is to be noted that wire was used 51 times in possibly contaminated and 27 times in surely contaminated wounds. Catgut was employed in only 18 of the former and 12 of the latter. Because of our previous satisfactory experience with wire in contaminated wounds it was used more frequently than catgut in the present series.

Cotton was employed in only one possibly contaminated wound. Cotton has been extensively utilized on this service for about eight years. It gives a much lower incidence of wound complication than catgut in either clean or contaminated wounds. Statistical analysis cannot however supply the entire story. In our experience, one sinus tract developing in the cotton sutured wound is more troublesome to both patient and surgeon than several infected catgut wounds. It is occasionally necessary to remove offending sutures by operation. We have never seen wire extruded from a wound or responsible for a sinus tract. It is true that most complications with cotton are due to faults in technique. It is also true unfortunately that despite the most meticulous care, occasional sinus tracts will form.

The cotton and cotton with catgut cases in this series are not numerous enough to be of true statistical significance. It is to be noted however that catgut and cotton when used in proximity to each other give a rather high incidence of complication. Two clean cases in which catgut and cotton were combined resulted in the extrusion of the cotton sutures. The reaction and possible infection with catgut makes for a pronounced foreign body reaction to the cotton. The use of cotton and catgut in the same wound is definitely poor technique. We tried it in this short series with resulting high incidence of complication even though the materials were practically isolated from each other by the interposition of the spermatic cord in the herniorrhaphies.

Many surgeons are reluctant to use wire for fear patients will object to it or be able to feel the material in the wound. If properly used, and cut on the knot, one cannot feel the sutures. Several years ago we operated a man who eventually became emaciated due to carcinoma of the stomach. His wire sutures had not been cut on the knot and could be felt and seen just beneath the skin. He experienced neither discomfort nor irritation. This serves as an illustration of the absence of reaction to the sutures. We have frequently employed wire in hydrocelectomies, mastectomies, tendon repairs and other procedures close to the skin surface. There has never been rea-

son to regret its use. Wire sutures enable us to feel safe in making a single transverse incision for bilateral inguinal hernia repair. With other materials the probability of wound infection makes this incision impractical for fear of damaging both repairs.

Stainless steel wire is slightly more difficult to handle than the other materials but one can in a few months learn to handle and tie it with ease. It possesses great tensile strength and it is inexpensive. Wire must be used as an interrupted suture at all times and the single square knot is reliable. One must be sure that a perfect square knot is tied—no other will hold with wire. Ends are cut on the knot. Suture nurses must be carefully instructed in the proper handling of the material. Kinks in the wire render the material difficult to tie and cause it to break easily. We have designed a simple spool holding dispenser which eliminates much difficulty. Care must also be taken to minimize the puncturing of gloves when using wire. Despite great care, our gloves have many more holes in them after using wire than following the use of other materials. It seems that this makes little difference as far as wound infection is concerned.

Cotton is inexpensive, easy to handle and gives a lower rate of wound complication than catgut. It must be used interrupted with ends cut on the knot. Its use is occasionally followed by the formation of troublesome sinus tracts and the extrusion of stitches. Hemostasis is of great importance when using cotton and must be complete. There is more tissue reaction to cotton than there is to wire.

Catgut is expensive, and it produces marked tissue reaction with actual necrosis about the stitches. It has the lowest tensile strength of all materials and gives by far the highest incidence of wound infections. It may be used as a continuous suture. Knots should be tied square with three throws. The single square knot with catgut is unreliable. The smaller sizes give best results and no catgut larger than 0 chromic should be used in the closure of the abdominal wound. We can reduce complications in the catgut sutured wound by using the smallest size that is feasible. Complications are found directly proportional to the quantity of reaction producing material left in the wound. We have used catgut in accordance with the foregoing principles. We are not satisfied with our results.

Stainless steel wire is, in our opinion, the finest suture material at present available. It is almost reaction free, chemically practically inert, economical, and gives fewer wound complications than any other type of material. We have reviewed a recent series of 586 operative wounds. Catgut wounds showed an infection incidence of 14.7 per cent. Seven and four-tenths per cent of wounds sutured with cotton

became infected. In 305 cases where wire was employed the incidence of infection was only 1.9 per cent despite the fact that wire was used in 51 of 70 probably contaminated and 27 of 39 surely contaminated wounds. Catgut was used in only 18 of the former and 12 of the latter.

Our 1.9 per cent rate of infection in wire sutured wounds we cannot equal with either cotton or catgut, and we feel that it is impossible practically or theoretically to attain this freedom from complication with other materials. The use of wire suture material in combination with transverse anatomically sound abdominal incisions provides maximum comfort for the patient and a minimum of wound complication.

A. Simple stitch abscess not prolonging hospitalization.

B. Pus accumulation in subcutaneous tissues not necessarily prolonging hospitalization or morbidity.

C. Involvement of deeper structures with sloughing of the fascia and prolonging disability.

Miscellaneous: Six hematomas which drained without infection and two cases in which intra-abdominal accumulations drained out through the wounds without primary or secondary infection.

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## THE EARLY DIAGNOSIS OF DISEASES OF THE CHEST\*

The early diagnosis of diseases of the chest is more important today than at any time in the history of medicine. Mass x-ray surveys have revealed that intrathoracic abnormalities and diseases are more frequent than has hitherto been suspected. Modern diagnostic procedures make early diagnosis more easily attainable than before. Modern medical and surgical procedures have increased the chances of control or cure in most diseases of the chest.

Not so long ago the physician had to rely on the history, the physical examination and inadequate bacteriologic study of the sputum to establish a diagnosis of intrathoracic disease. Diagnoses could be made during this era only when the pathologic process was in an advanced stage. In recent years, however, fluoroscopy and roentgenography have become universally available. Bronchoscopy has been perfected so that it can now be performed with only slight discomfort to the patient and with little risk. Better bacteriologic technics have been developed. Aspiration biopsy of lung tumors is helpful in certain cases. The advance in medical and surgical therapy of chest lesions has kept pace with the diagnostic developments.

In spite of these facts, 60 per cent of tuberculosis patients who are referred to sanatoriums have far advanced disease, and only 10 per cent have minimal lesions. Less than 25 per cent of the patients with cancer of the lungs are referred for surgery before extension of the tumor has occurred. Recently Overholt discovered that among 153 patients with cancer of the lung an incorrect diagnosis had been made in 95 cases (60 per cent). Treatment based on this had been maintained for long periods of time.

There may be several reasons for the delay in diagnosis. The patient frequently delays going to the physician because he has few or no symptoms; the presenting clinical picture often suggests another diagnosis; physical examination is notoriously unreliable; and the application of rigid diagnostic methods is often delayed because the physician has not developed a sufficiently strong suspicion of the underlying disease.

No attempt will be made to cover completely the symptoms associated with intrathoracic diseases, but the following points require emphasis. Almost all the diseases of the chest have an early asymptomatic stage, during which the pathologic process can be discovered only by X-raying the chest. This stage is apt to be so mild that the seriousness of the underlying lesion is overlooked. Cancer and tuberculosis may masquerade as each other, or as any of the commonplace diseases of the chest, or as an entirely foreign clinical picture, such as arthritis.

Physical examination of the chest is essential in the evaluation of any patient, but the time has come to recognize its limitations as well as its value. As early as 1933, Sampson and Brown reported that moderately coarse rales at an apex were the only reliable data obtained on physical examination, and added that these were present in only 27 per cent of the minimal cases. They analyzed the occurrence of the five cardinal signs and symptoms of tuberculosis in a series of 280 cases with minimal disease. Tubercle bacilli were found in the sputum in 35 per cent, rales in 27 per cent, hemoptysis in 26 per cent, pleural effusion in 12 per cent, and X-ray evidence of pulmonary tuberculosis in over 99 per cent. In

\*From *Tuberculosis Abstracts*, Volume XIX, Number 4, issued monthly by the National Tuberculosis Association.

(Continued on Page 322)

## PRESIDENT'S PAGE

*To the Members of the Kansas Medical Society:*

When a doctor's thoughts are fixed on getting away for a vacation or clearing up the daily grind of practice in spite of the summer heat, it is difficult to budget any time or especial attention for civic affairs. However, we have a primary in the offing which deserves some little thought by every member of our state organization.

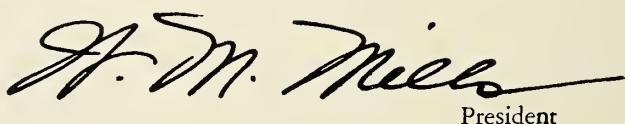
We refer of course to the selection of candidates for state offices and the legislature on both the Democratic and Republican tickets. As medical men we are interested in backing with our votes men who are courageous, honest and have a keen interest in the things that our profession symbolizes. As a result of such an interest, the 1945 legislature passed the enabling act which permitted the establishment of Kansas Physicians' Service.

An intelligent interest on the part of the candidate in the problems of public health, medical education, extension of hospital care and in the medical care of the wards of the state in tubercular, mental and corrective institutions appeals strongly to us as voters.

To evaluate the attitude and capacities of the various local candidates, it is important to make their acquaintance and exchange ideas on some current problems in your own community or in a broader field.

I have often thought and said that the private practice of medicine will stand or fall according to the quality of the aggregate service we render the public. This simply illustrates the potential influence of our profession in every county in Kansas.

Vote, but stop and look them over first.



H. M. Miles  
President

## EDITORIALS

### Indoctrination Course

Whether entirely practical for Kansas or not, a new idea has been presented by the Los Angeles County Medical Society that we believe worthy of comment. The innovation resulted indirectly from the war, which brought many hundreds of physicians to California where they often applied for membership in the county societies.

These doctors, coming from all states in the union and new in California, frequently had no knowledge of existing laws pertaining to the practice of medicine and surgery in their new state. A program was designed, therefore, to assist these men.

The Los Angeles County Medical Society passed a regulation requiring all applicants, before they are voted into membership, to take an indoctrination course and to pass an examination. The society set up a committee to prepare a course of study consisting of instruction in professional ethics, malpractice prophylaxis, laws governing medical practice and narcotics, public health ordinances and laws governing birth and death. The course will also include a history of the county medical society, its aims, accomplishments and struggles. The applicants will be told of the various projects in which the society is engaged such as, in the case of California, California Physicians' Service. They will be instructed on Workmen's Compensation laws, the duties of the coroner's office, the resources at their disposal in the state, the laws governing the operation of the county hospital, etc. The applicants will be instructed on many problems facing medicine and advised concerning accepted standards regarding expert testimony.

The idea is intriguing also in Kansas because a physician joining a county society will be an infinitely more valuable member if he could be told in advance of the advantages as well as the responsibilities of membership. If he had a clear review of laws and of resources that apply to the medical profession, he would frequently be saved many disturbed hours in trying to discover this information. If he understood the projects his society sponsored he could participate in those projects more effectively and earlier. The applicant would appreciate this service.

Some of the larger county societies in Kansas are already planning a service of this kind to prospective members. The Journal would appreciate an account of these plans and will publish that information. Smaller societies might offer a similar benefit on perhaps a less elaborate scale. The state society could compile material and send an outline to the secre-

taries of all county societies. Such a service from the state society would prepare the information on a state level. There would then be no difficulty in adding to this information whatever the county society would wish to include of local interest, such as regulations pertaining to hospital staffs, local medical resources, etc. At any rate, it sounds like a project in which we believe the state society should participate.

### Veterans Administration Rehabilitation

General Paul R. Hawley has repeatedly made the statement that the Veterans Administration shall be run for the benefit of the veteran. Any improvements in any phase of medical care for the veteran shall be made as rapidly as they can be placed into effect. The sincerity of his remarks is borne out by the fact that already the Veterans Administration has contracted with state medical societies, beginning with Kansas, to render medical care in the veteran's home community and by his chosen physician.

The Veterans Administration has also embarked on a pretentious rehabilitation program for the veteran. Details of this project were outlined at a regional conference on industrial health held in Denver on June 4. The speaker was Donald A. Covalt, M.D., assistant medical director, Medical Rehabilitation, Veterans Administration, Washington, D.C. Dr. Covalt said that as a result of a survey made of the United States Army, the need for this program was established. When it was learned that 42 per cent of all enlisted men and 13 per cent of the officers in the Army had not completed high school, the Veterans Administration determined that educational opportunities should be given patients receiving long-time care at Veterans Administration hospitals. There are today 13 branch offices, all of which have directors who are doctors of medicine. Under the Veterans Administration there are 107 hospitals offering at present 142 academic courses. This represents scholastic training to patients in each instance on a prescription basis by the physician in charge. It has definitely been ruled that education under this category does not affect the patient's benefits under the G. I. Bill of Rights or under Public Law 16.

Dr. Covalt told of special courses offered to the hard of hearing at the Borden General Hospital at Chickasha, Oklahoma. Vocational instruction is widely used in neuropsychiatric hospitals, and in contrast to the above, academic training is stressed in tuberculosis hospitals.

In numerous instances contracts have been made with industrial firms for piece work that is clean and quiet which the patient may work on either in bed or at the bedside. Again this is on a prescrip-

tion basis for each individual and is limited in all instances to four hours daily work. The patient is paid all money due for the work performed. Experience has proven that patients enjoy this activity. Boredom is relieved and, surprisingly, these handicapped persons frequently turn out more and better work than is done in the same length of time by employees in the factory. Therefore, the arrangement is satisfactory not only to the patient and the Veterans Administration but to industry as well.

There are 2,000 patients with spinal cord injuries in Veterans Administration hospitals. The rehabilitation department is trying to make these men economically independent in spite of their disabilities. By way of example, Dr. Covalt told of a contract made by the Veterans Administration and the Bulova Watch Company. Expert instructors from the Bulova Watch Company are brought into hospitals and all men capable of learning this work are given permission to study. The length of time spent daily at this exercise depends upon the individual patient's physical condition. Sixty per cent of the men with spinal cord injuries are taking advantage of this training. After leaving the hospital they can go to the Bulova Company where they receive final training in watch repair. They are then given jobs averaging \$75 a week plus a commission on work completed.

Rehabilitation will be included in all new hospitals to be built and as rapidly as possible will become part of the program of all existing hospitals. The program, however, is greater than merely the training a veteran may receive.

During the war 87 per cent of our industries used handicapped persons. In general the program was successful and there were many instances where they worked better than normal persons. The accident rate was lower and absenteeism was less. However, now that the war is concluded, handicapped persons are being laid off and it is becoming increasingly difficult for persons with disabilities to obtain employment. There apparently is no longer a general interest in the individual's ability to perform a specific task. If he is handicapped, be he veteran or not, employers will not take him. The rehabilitation program attempts to carry its work into industry and to obtain for these disabled veterans adequate employment.

The talk was concluded by Dr. Covalt with the plea that the people of America recognize the fact that these people are employable and that if recommended for a specific position the employer may rest assured that they have been trained to do the required work. In all rehabilitation programs operated by the Veterans Administration, the first step is physical restoration. Proper training is the second.

### Stormont Library Into New Quarters

The Stormont Medical Library is now occupying new quarters recently acquired and furnished through the interest and efforts of Chief Justice Harvey and other members of the Supreme Court, acting in the capacity of directors of the State Library, and Governor Schoeppel and other members of the Executive Council. These quarters consist of three rooms on the third floor, south wing of the state house. They are easily accessible, pleasant, and include a comfortable reading room. A full-time librarian is in charge, and the library is open each day from 8:30 a. m. to 5:00 p. m.

This library was established through the gift of an endowment fund by Mrs. Jane C. Stormont in memory of her husband, Dr. David W. Stormont, and was designated by law to be a part of the State Library. In accordance with the wishes of Mrs. Stormont, it was declared "to be forever free for the people of Kansas and particularly for the medical profession." In the past, partly because of inadequate housing and partly because of insufficient funds and help, Mrs. Stormont's dream of service has not been as completely fulfilled as it might have been. It is hoped that plans for the future may develop something truly worth while, especially for those who do not have adequate medical library service near them.

Books and periodicals will be loaned anywhere in the state, the only cost being for transportation. One service which a few doctors are making use of is the loan of certain designated current periodicals as they are received in the library. The library also is equipped with some excellent bibliographical tools and the librarian will be glad to prepare bibliographies on special subjects upon request. All requests for loans, or for any type of service, should be directed to the Stormont Medical Library, State House, Topeka, Kansas.

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### Current Population Trends

As a means of guarding against an eventual downward trend in population, the United States is conducting studies to investigate conditions affecting our population growth, as are a number of other countries. It is generally recognized that the sharp spurt in birth rates during the war period was of temporary nature and will continue for only a year or two.

Those who believe that our population will rapidly increase in the years to come are basing their opinions on the war period trends. In view of the continued high marriage rate and the demobilization of men from the armed forces, it is safe to predict that the birth rate will remain relatively high for a short period, but it is equally reasonable to assume

that the rate will soon return to about the prewar level.

Birth rates during the years 1941 to 1945 were the highest in more than a decade, the number of children being born in those years exceeding the total for any comparable period in the history of the country. At the same time, the civilian death rate dropped to the lowest level on record, and as a result the excess of births over deaths during that period amounted to 7,750,000 as compared with 5,200,000 in the preceding five-year period.

A statistical chart illustrating population trends has been prepared by the Metropolitan Life Insurance company to show the net reproduction rate since 1920. Conditions of fertility and mortality at that time indicated that a cohort of 100 white girls born in that year would eventually produce 125 daughters and 157 granddaughters. During the 1930's, however, the rate dropped steadily and by 1936 the net reproduction rate was below maintenance level which, according to prevailing fertility and mortality conditions, would have led to a population decrease of five per cent a generation. By 1940 our population was little more than reproducing itself, and in 1943 the rate had climbed to 1.235. In 1945 it was 1.138.

Our present population has a high proportion of women in the reproductive ages, but this situation, of course, is only temporary. When allowance is made for this fact, by taking into account mortality rates and reproduction rates specific for age, we have the "true" rate of natural increase, which is generally much below the observed rate.

The outlook for population growth is not as bright as would appear from surface indications. Studies in the United States to evaluate statistics on population trends must form the basis for a population policy consistent with our traditions and current needs.

### Possibility of Doubling Penicillin Supply

Research workers at the University of Wisconsin have developed a new strain of mold which opens the possibility of doubling the nation's supply of penicillin, according to an announcement made recently by the university's Alumni Research Foundation. This news is of especial importance since the demand for penicillin has increased far beyond the production built up in the last three years. Because of the acute shortage, the drug was recently returned to an allocation basis by the government.

American production of penicillin during December, 1945, was 700 billion units, or something over 1,000 pounds of the powdered sodium form of the pure chemical, but it was still short of demand for human use in this country by at least 100 billion units. In addition, demand also is rising rapidly for veterinary use in the United States.

### Committee Chairmen for 1947 Meeting

Dr. Dwight Lawson, Topeka, has been appointed general chairman for the 1947 annual meeting of the Kansas Medical Society, to be held at the Municipal Auditorium, Topeka, May 12-15, 1947. Preliminary plans are already being made, and Dr. Lawson announces the appointment of the following committee chairmen:

Scientific Program—Dr. Don C. Wakeman  
 Commercial Exhibits—Dr. L. A. Curry  
 Scientific Exhibits—Dr. Henry S. Blake  
 Arrangements—Dr. B. I. Krehbiel  
 Reception—Dr. Lucius E. Eckles  
 Publicity—Dr. Harry J. Davis  
 Entertainment—Dr. James D. Bowen  
 Auxiliary—Dr. Leo A. Smith

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### New Pharmacopoeia

The appearance of a new Pharmacopoeia this fall, which will become official on April 1, 1947, is the climax of intensive investigation and study by groups of authoritative workers in medicine and pharmacy. Each revision is intended to reflect the latest knowledge in medical practice and drug standardization, and the speeded-up revisions of today, with supplements, have been necessary to keep the U.S.P. in line with the rapid progress of medical research.

A striking feature of this period of revision for the Pharmacopoeia has been the sharp trend toward medicines having specific physiologic action. The important representatives of the sulfanilamide group of drugs are, of course, recognized, including sulfamerazine and its oral and injectable forms. Penicillin sodium and penicillin calcium and some of their dosage forms, although under Federal control, have received Pharmacopoeial listing.

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### Committee on Heart Disease Meets

The Committee on the Study of Heart Disease held its first meeting on Sunday, June 23, at Emporia and discussed in detail the incidence of heart disease and the lack of uniform nomenclature in reporting it. The chairman of the committee, Dr. Philip W. Morgan, Emporia, has reported to the Journal that, in view of communications from the Veterans' Administration and other agencies, the committee outlined the following procedures.

1. Urge each local or regional medical society in Kansas to assign a local man to give a talk to that society during the year, giving a review of local and state cardiovascular deaths during the preceding year and then discuss the four types of heart disease, congenital, rheumatic, luetic and hypertensive.

2. In hospitals where nursing schools exist in the state, that some local physician be asked to prepare and deliver a short series of talks outlining the physiology and nomenclature of heart disease to the senior nurses so that they may be of more benefit to the patient and can better cooperate with the physician in charge.

3. That every hospital record clerk, every hospital librarian, every society library and every physician secure a copy of the book, "Criteria for the Diagnosis and Classification of Heart Disease," a book published without profit by the American Heart Association, 1790 Broadway, New York 19, New York.

4. Advisory suggestions concerning the accomplishment of paragraphs 1 and 2 above can be procured by addressing the Committee on the Study of Heart Disease, care of the Kansas Medical Society, 406 Columbian Building, Topeka, Kansas.

## EXECUTIVE OFFICE

Appearing here each month is an item selected by the executive office as being of general interest to the membership. Since these subjects are frequently new, they have not been discussed by the Council or by committees. Therefore, opinions expressed are individual and not necessarily those of the Society.

The purpose of this column is to acquaint the membership with Society problems. Announcing them in advance of formal studied opinion gives everyone an opportunity for expression. Comments are invited and will be presented to the Council or committee.

Early in the fall Society activities will begin again. New committees are already appointed and many plans are under way for a busy year. Dr. Mills has suggestions that will be presented to the Council. These include constructive programs which, when placed in effect, will make your Society of greater service both to the public and to the profession than ever before.

Your president will announce those plans later in the year. For now, may we suggest a few activities that might be considered? They have come from our conversation with members, from past committee meetings, from the journals of other states, from the A.M.A. Only a few have been approved by our Society, so for now the discussion is all in the form of a question. Do you like or dislike any of these activities and can you suggest others?

For instance, how can the Society improve its information to members? Even important far-reaching programs such as Kansas Physicians' Service and the Veterans Administration service have never been fully explained, long after they are in operation. Would regular news letters to the membership, as sent by Indiana for example, as a supplement to the Journal, be the answer?

Kansas Physicians' Service is now six months of age. Approximately 850 physicians have agreed to participate in this program and something more than 6,000 persons have enrolled. While this is not at all discouraging, the progress report could be much better. It will improve in direct proportion to the active support given by the doctors of Kansas. Kansas Physicians' Service is a Society project, planned, financed and operated by the Society. It is a public service project, and to date the one constructive answer to the problem of government control. When sufficient people are protected under voluntary medical-sponsored plans, government pressure will subside. Therefore, it should follow that individual and Society assistance to this project should set no maximum limits.

Every member should understand both the theory and the practice of Kansas Physicians' Service. Who better than the individual physician is there to obtain new members? Survey the result a year from now, if every member encouraged his patients to organize groups or join groups already organized; if he spoke before lay groups on this subject; if he offered to distribute literature in his reception room; if he served as the self-appointed representative of Kansas Physicians' Service in his own community.

Add to that the strength of the county society, and miraculous results could be obtained. If county societies would vote to make Kansas Physicians' Service a local project, enrollments would soar. By way of example, a society might advertise this public service in newspapers and thereby stimulate enrollment. But more of that later.

Nothing is of more importance today than the medical society agreement with the Veterans Administration. A

means must be found for unifying this program, and that also requires a great deal of work during the coming year.

But what of other problems for the coming year; what of committee activities?

Would you approve of a new industrial medicine program for Kansas? Suppose your committee could meet with industry and with labor to arrange an outline on industrial health that is acceptable to all parties concerned and then disburse this information as standard procedure.

What of the cancer problem and the large sum of money raised in Kansas? Individual donations were made in the hope that something could be done to save lives. The public now looks to the medical profession for a tangible benefit. Is the organization of county society-operated clinics a step in that direction?

Do you have suggestions for improving the graduate education program in Kansas? If the present plan of bringing lecture courses into the doctor's home community is not the entire solution, what might be added?

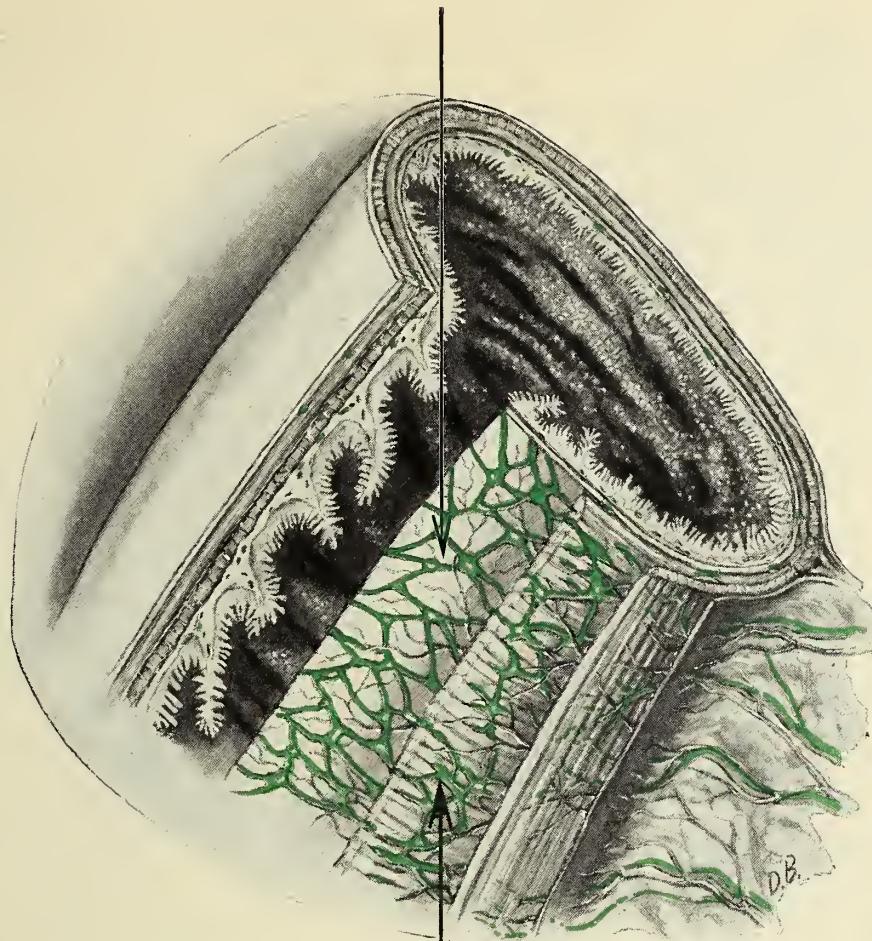
The need for preserving the history of medicine in Kansas has been often discussed. Actual progress on this work has been slow because much early material is now difficult to collect. Perhaps for the next year something else could be tried. How about a history of Kansas medicine in this war? Never again will that material be as accessible as at present, and certainly that glorious chapter of Society history deserves preservation.

Increased activities in the field of public relations have been recommended to the Society. A successful program in this field will add public support and confidence. If this could be accomplished many of the problems now confronting the Society would be solved. It is necessary, however, to be judicious in the use of the press, the radio, and whatever other means are employed. Preliminary steps are necessary before such a program can be started. For instance, there should be a clear understanding of what results the Society wishes to obtain. Next the choice of media should be selected, and finally cost should be budgeted in advance. After those factors are established, then a large portion of the membership should be asked to contribute material or time to this project.

All the above is merely a beginning on what the Society might accomplish in the coming year. Added to this list could be a program to more closely integrate the work of the Society with other organizations such as the A.M.A., the Kansas State Board of Health, the University of Kansas School of Medicine and others. There are also many problems of purely local interest such as the Society's attempt to supply adequate medical care to all persons in the state. These will be discussed during the coming months by the various committees and by the Council. Their decisions will direct the course your Society will take. Any member having suggestions to offer on these or any other activities in which the Society might engage is cordially invited to write the executive office.

### Books Needed in Manila

An appeal for technical and scientific books and periodicals has been received from the Department of Agriculture and Commerce in Manila. Before the war, the scientific library of the Manila Bureau of Science was known as one of the largest in that part of the world, but the entire library was destroyed by the Japanese and the task of rebuilding has just begun. Anyone who wishes to contribute books or publications may send them to the Scientific Library, Bureau of Science, Manila, Philippines.



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the highly refined mucilloid of a seed of  
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RESEARCH IN THE SERVICE OF MEDICINE



## MEMBERS

Dr. Kenneth J. Gleason, a member of the Harvey county society, is now on terminal leave after having served five and a half years in the Army. He recently returned to this country from the ETO, where he had served with the 202nd General Hospital and the General Dispensary in Paris.

\* \* \*

Col. Mahlon H. Delp, who has been stationed at Crile General Hospital, Cleveland, was released from the Army last month and has returned to his home in Kansas City.

\* \* \*

Dr. W. G. Low, who has been practicing in Coffeyville for the past 13 years, moved to Colorado last month and has opened an office in Colorado Springs.

\* \* \*

Dr. Russell Nevitt, who has been serving in the Army for five years, has announced the opening of an office in Iola. Before the war he practiced in Kincaid and Moran.

\* \* \*

Dr. Robert R. Means, who has been practicing in Osawatomie for 16 years, is closing his office there and opening a new office in Red Lodge, Montana.

\* \* \*

Dr. John Neinstedt, formerly of Hartford, was recently released from the Army after four years service and is now associated in practice with Dr. H. L. Collins of Beloit.

\* \* \*

Dr. George W. Wright, who has been practicing in Neodesha for three years, moved to Webb City, Missouri, last month and has opened an office there.

\* \* \*

Dr. C. W. Haines, Haven, was in Chicago recently to take postgraduate work at the Cook County Hospital.

\* \* \*

The Shawnee County Medical Society has announced the return of two more of its members who have been serving in the Army, Dr. H. L. Kirkpatrick and Dr. Clyde B. Trees. Both have re-opened offices in Topeka, Dr. Kirkpatrick specializing in EENT work and Dr. Trees specializing in orthopedics.

\* \* \*

Dr. John L. Lattimore, Topeka, has filed as a Republican candidate for a second term as representative from the thirty-fifth district.

\* \* \*

Lieut. Col. Maurice A. Walker, who has been stationed at Dibble General hospital, Menlo Park, California, is now on terminal leave and is vacationing on the west coast. He plans to re-open his office in Kansas City in September.

\* \* \*

Dr. William T. Rich has returned to his practice in Neodesha after spending three and a half years in the Navy. At the time of his discharge he held the rank of lieutenant commander.

\* \* \*

Dr. A. R. Chambers, Iola, was elected governor of the 136th district, Rotary International, at a convention held the latter part of April.

\* \* \*

Dr. Oliver L. Martin, who was recently released from the Army medical corps, has announced the opening of an office in Columbus.

Dr. Mayo Poppen, Burr Oak, is now taking postgraduate work at the Harvard School of Medicine and in the fall will begin a residency at Massachusetts General Hospital, specializing in eye and ear work.

\* \* \*

Dr. A. E. Cooper, who was released from the Navy last month after 29 months service, has announced the opening of an office in Norton. Holding the rank of lieutenant commander, Dr. Cooper served varying periods of time in England, at the Hutchinson Naval Air Station, and on a repair ship in the Pacific.

### New Surgical Film Available

A 35-minute film, "Managing Fresh Wounds of Violence," has been produced by Bauer and Black, Chicago, and is available for presentation before surgical and medical groups without rental charge. The full color silent film has been in production for more than a year, and is released with the approval of the American College of Surgeons. Complete information may be secured from the Film Library, Bauer and Black, Chicago 16, Illinois.

### New Doctors in Kansas

The Journal has received information that several new doctors have opened offices in Kansas or plan to do so in the near future. Dr. Carl G. Seigel, formerly of Kansas City, was recently released from the Army medical corps and has announced the opening of an office in Ellis. Dr. Rodney Jones, formerly instructor in the medical school at the University of Colorado, is planning to locate in Goodland. Dr. John Aldis, who has spent the past three years as an Army flight surgeon, will take over the clinic in Council Grove operated for the past ten years by the late Dr. T. P. Haslam.

Dr. John H. Lathrop, recently discharged from the Navy, has announced the opening of an office in Smith Center. Another physician recently released from the Navy, Dr. F. J. Bice, will open an office in Wakeeney.

### Salaries for VA Resident Physicians

A new salary program for resident physicians training in Veterans Administration hospitals has been announced, providing salaries up to \$1,800 a year, plus maintenance, subsistence and tuition allowances. First-year residents, holding junior grades, will receive \$900; second-year, intermediate grade, \$1,350; third-year, senior grade, \$1,800. Most doctors released from military service will qualify for the senior grade, and those who have just completed internship will progress through the three grades.

In addition to their salaries, VA resident doctors will receive \$1,500 annual maintenance and subsistence allowance if such facilities are not provided at hospitals. The Administration will also pay all tuition fees for medical courses resident physicians take as part of their training, up to a limit of \$2,000 for three years.

Qualified physicians interested in applying for assignment to the VA department of medicine and surgery should contact the personnel officer, VA Hospital, Wichita, Kansas, for complete information.

Hydrolyzates cost from \$2.50 to \$18 a pound, reports the Office of Pharmacal Information. The average dosage for a man suffering from chronic starvation might be five ounces a day for 21 days, allowing for administration of other food, or about \$15 per patient. Pure synthetic aminos cost as much as \$500 a pound. Quantity production, just getting started, will undoubtedly cut the price considerably, as in the case of vitamins.

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**SULFUR FOAM APPLICATORS**



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## THE KANSAS PRESS LOOKS AT MEDICINE

### *Somebody Is Guilty*

It never ceases to be a source of wonder to the people of Kingman county at the carelessness in some communities in the state which amounts to nothing more nor less than criminal negligence, when we read of the consternation created by an outbreak of diphtheria.

Within the past two weeks the people of Fredonia have been called upon to pay the penalty for their inexcusable neglect for not having their children immunized against this preventable disease. There was a mad scramble for antitoxin and the supply was soon exhausted and another supply was hurriedly sent in. Children were ordered to stay away from all gatherings, no school was held during the last week of the term, all commencement exercises were postponed indefinitely and the churches have cancelled their services. It would appear from the news reports that the people are all excited about the welfare of their children. There have been no children choked to death yet, but if they do, it will be small consolation to the parents to know that there is an unfailing remedy and that all this hullabaloo about its use came too late. No doubt they vaccinated their hogs—and let the children get diphtheria.

Silly, isn't it? And so useless! This is an old, old story about Kingman county but it is still worth repeating: There hasn't been a death from diphtheria in Kingman county for almost twenty years, and there have not been to exceed half dozen cases in the county in all that time, and they were children who came from outside. And those few cases caused no excitement, because there was no more danger of an epidemic than if the sick child had had the toothache. The county pays the small expense and by working through the schools it takes less than a week to immunize every child who has not previously been treated.

We hear a lot now about advertising the advantages of cities and communities. Kingman is going to vote soon on a levy for that purpose, but Kingman county—and no other county—can offer anything better than that the entire population is immune to diphtheria.—F. J. Cloud, Kingman Journal, May 24, 1946.

\* \* \*

### *The New County Health Plan*

The new model public health program proposed for Cowley county represents a major development that deserves serious study and consideration by everyone concerned.

Certainly, the plan is a comprehensive one, offering a large expansion in health services. The five-year program would incorporate and coordinate all health work now being done by county, city and school agencies. Services would be extended into rural areas that are not being reached effectively under present arrangements. There would be no additional cost to county taxpayers for the first three years, as the plan is now outlined, with an expenditure of \$2,000 involved for each of the last two years. Cost, therefore, is no real issue.

Objections to the program already are being voiced from some sources. The wisdom of abolishing long established and highly successful local institutions is questioned. Centralized control with its customary red tape and other characteristics, always is a matter to be regarded seriously in these times. The plan to establish a department office

in Arkansas City to serve this part of the county comes in answer to reluctance to yield any more control of local functions to outside sources.

The field of public health is an extremely broad and an exceedingly important one. Much valuable work can be done along many different lines, some of which are barely touched under present arrangements. Further progress along this line definitely is needed.

Whether the model plan proposed fits the bill is something the people of Cowley county, through the various public and semi-public agencies concerned, must decide.—Arkansas City Traveler, May 7, 1946.

## COUNTY SOCIETIES

The Crawford County Medical Society met May 23 at the Hotel Besse, Pittsburg. Dr. C. D. Bell told of his experiences with the Army medical corps in the Aleutians, illustrating his address with colored slides, and Dr. C. B. Newman discussed his war experiences in Africa, Sicily, Italy, France, Germany and Belgium. A report of the state meeting of the Kansas Medical Society was given by Dr. C. H. Benage.

\* \* \*

Members of the Clay County Medical Society entertained their wives at a dinner meeting at Cedar Court, Clay Center, on June 12. Mr. Oliver E. Ebel, Topeka, executive secretary of the Kansas Medical Society, discussed current federal legislation.

\* \* \*

The Central Kansas Medical Society met June 20 at the city hall at Russell. Dr. P. T. Bohan, Kansas City, Missouri, spoke on "Treatment of Nephritis," and Dr. Alfred J. Horejsi, Ellsworth, discussed "Diagnosis and Treatment of Malaria in the United States Army."

\* \* \*

A meeting for members of the medical societies in McPherson, Marion and Harvey counties was held at the Newton country club on June 3. Dr. Thomas G. Orr, professor of surgery at the University of Kansas hospitals, Kansas City, presented a paper on "Cancer of the Pancreas."

## DEATH NOTICES

### HENRY CLAYTON ULERY, M.D.

Dr. Henry C. Ulery, 71, a member of the Crawford County Medical Society, died April 25 at the home of his daughter in Girard. He was graduated from the University Medical College of Kansas City in 1911, and since that time had practiced in Girard, McCune and Redfield.

\* \* \*

### CHARLES MELFORD STEMEN, M.D.

Dr. Charles M. Stemen, 80, an honorary member of the Wyandotte County Medical Society, died May 29 at Kansas City. A graduate of the Fort Wayne (Indiana) College of Medicine, he had practiced in Kansas City for many years, specializing in surgery.

\* \* \*

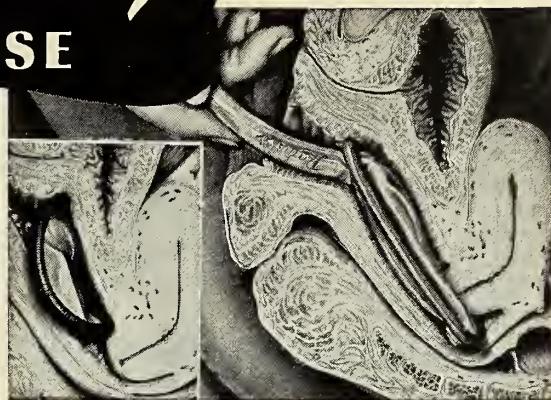
### CLEMONS C. LEWIS, M.D.

Dr. Clemons C. Lewis, 68, a member of the Clay County Medical Society, died April 25. A graduate of the University Medical College of Kansas City in 1904, he had practiced in Kansas since that time at Clifton and at Industry, specializing in obstetrics.

# Simplicity IN USE

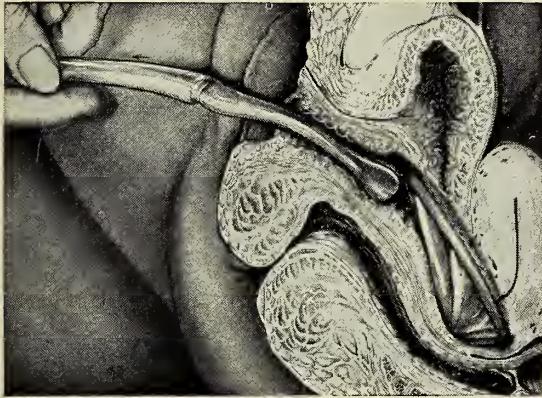


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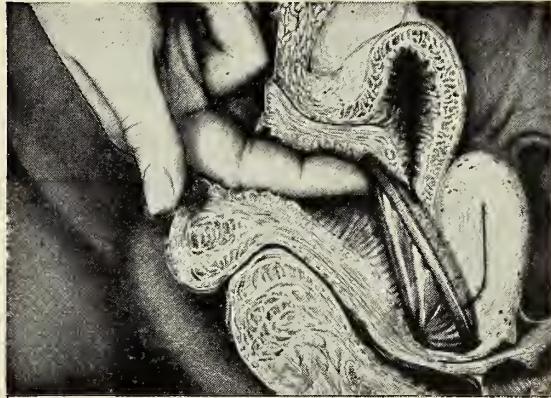


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### Early Days With the Board of Health

The Kansas Public Health Association honored S. J. Crumbine, M.D., at a banquet at Wichita on June 6, 1946. Dr. Crumbine, now 83 years of age and still active enough to play a daily 18 holes of golf, was as keen, as alert and as witty as in the days during which he served Kansas as its first director of public health.

Dr. Crumbine related many early experiences in public health work and included in his reminiscences anecdotes that, except for his vivid memory, would have been lost. A few of these stories are reported below to preserve a portion of the history of early Kansas as told by a principal in the formation of this history.

Dr. Crumbine said that the legislature established a State Board of Health in 1885 and placed a maximum limit on expenditures at \$5,000 a year. Although this seems almost humorous at present, it should be remembered that there were only five or six eastern states that had previous health laws. At that time the greatest health problems in Kansas were "lungers" or consumptives. People were in terror of this disease but until that time no one had made any serious attempt to study its prevention. Other serious problems were typhoid and diphtheria.

On June 2, 1904, Dr. Crumbine was appointed secretary and executive officer of the Kansas State Board of Health. His salary was \$1,200 a year and the total budget in 1904 was \$3,080. In that year Dr. Crumbine noticed an Army report by Walter Reed pointing out for the first time that lime had been found on the legs of flies. According to Walter Reed, this meant that flies were carrying material away from outhouses at Army posts. If that were possible, flies could then become a health menace, and Dr. Crumbine began his crusade against flies.

In 1905 the first Fly Bulletin was issued. Posters were placed in railroad stations, post offices and all public buildings. Screening windows was encouraged and shortly thereafter the first fly swatter, known as a fly bat, came into being. A Boy Scout leader, Frank H. Rose, school teacher at Weir City, told Dr. Crumbine that his Scout troop wanted to assist in the anti-fly campaign. Rose bought a roll of screen and cut it up in 4x6 inch pieces. He begged advertising yardsticks from the local hardware dealer which, when cut into one-foot lengths, served as handles. These fly bats were distributed to every house in Weir City and the campaign was on.

Dr. Crumbine's attention was next turned to tuberculosis. He wrote each doctor in the state asking for a tuberculosis census and, to his amazement, found that 427 cases were reported. Although this figure in no way illustrated the total number of cases, it was a heartening stride in the elimination of the disease since the medical profession showed its willingness to cooperate. A further impetus came to the tuberculosis program in 1908 when Dr. Crumbine attended an International Congress on Tuberculosis. Representatives from 33 nations were present and Dr. Robert Koch addressed the Congress. Elihu Root made the statement that disease may be controlled through knowledge, so Dr. Crumbine upon his return determined to spread knowledge in Kansas. On December 3, 1908, he asked the governor to call a state conference. Although less than 20 persons were expected to attend, the legislative hall was filled and the Kansas Society for the Study and

Prevention of Tuberculosis was born on that day. By 1911 this work had progressed to the point where a tri-state sanitation district was organized and Dr. Thomas Parran, Jr., was the first director of this program, which included Kansas.

During the early days it was not only popular theory but generally conceded by the medical profession that water would be purified after flowing overground a distance of seven miles. In those days raw sewage was dumped directly into the rivers everywhere. Dr. Crumbine, in an effort to prove or disprove this theory, traveled in a steel canoe from Topeka to Lawrence, taking samples of water every half mile. These samples were tested at the laboratory at Kansas University and impurities resulting from Topeka sewage were still evident after 28 miles.

A campaign against the common drinking cup began on March 12, 1909. A sanitarian on the Board of Health went to the depot in Kansas City, Missouri, and took swabbings from the drinking cups on all trains traveling through Kansas. Findings were dramatic. Many varieties of germs were found on all drinking cups. The report was prepared and sent to all railroads operating through Kansas. Only one railroad wrote back saying it would not care to cooperate in eliminating this health hazard, but was finally persuaded to do so when it learned that all other railroads had complied.

A smallpox epidemic traced to a roller towel in a small hotel turned Dr. Crumbine's attention to this menace to public health. Samples of material on used towels were tested in laboratories and were found to contain hair and skin particles, fecal contamination, staphylococcus germs and others. By September 1, 1911, the State Board of Health had ruled that common roller towels in public places must be abolished.

Much early work was done on food and drug laws, giving Kansas a high place in the pioneering efforts in this field. Kansas had the second Child Hygiene program in the United States and, during World War I, succeeded through cooperation with the United States Army in providing the best venereal disease control program in the United States.

These, just a few of the stories of early experiences of the State Board of Health under a dynamic leader, illustrate the hardships that were encountered in a pioneering day. Many others could be added to this list, but these are enough at least to illustrate the advancements that have been made in the field of public health within the span of one lifetime.

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The proposal has been made that when the premarital serologic test is made, it include a reading of the Rh factor in each applicant. That may not be feasible at the present time, but at least that would afford some information of value. What should be possible is the making of such a test in every pregnant woman at the time of the prenatal examination. The necessary procedure is not difficult or expensive; it can readily be mastered. Laboratories should arrange to provide it and practitioners undertaking obstetric deliveries should be urged to have it done. Hospital services in particular should make it a part of their routine. The knowledge thus obtained should prove of great value for its effects in lowering the possible occurrence of this unfortunate outcome of a pregnancy.—New York State Journal of Medicine, January 1, 1946.



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½ oz. of Ovaltine and 8 oz. of whole milk,\* provide:

CALORIES .....	669	VITAMIN A.....	3000 I.U.
PROTEIN.....	32.1 Gm.	VITAMIN B <sub>1</sub> .....	1.16 mg.
FAT.....	31.5 Gm.	RIBOFLAVIN.....	1.50 mg.
CARBOHYDRATE.....	64.8 Gm.	NIACIN.....	6.81 mg.
CALCIUM.....	1.12 Gm.	VITAMIN C.....	39.6 mg.
PHOSPHORUS.....	0.939 Gm.	VITAMIN D.....	417 I.U.
IRON.....	12.0 mg.	COPPER.....	0.50 mg.

\*Based on average reported values for milk.

## BOOKS RECEIVED

*Synopsis of Pathology.* By W. A. D. Anderson, M.A., M.D., F.A.C.P. Published by C. V. Mosby Company, St. Louis, Missouri. 741 pages. Price \$6.50.

*Textbook of Pathology.* Fourth Edition. By William Boyd, M.D. Published by Lea and Febiger, South Washington Square, Philadelphia 6, Pennsylvania. 1008 pages, 490 engravings, 29 colored plates.

*Fractures, Dislocations and Sprains.* Fourth Edition. By John Albert Key, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. Published by C. V. Mosby Company, St. Louis, Missouri. 1322 pages. Price \$12.50.

*Modern Attack on Tuberculosis.* By Henry D. Chadwick, M.D., and Alton S. Pope, M.D. Published by the Commonwealth Fund, 41 East 57th Street, New York City. 132 pages. Price \$1.00.

*Diabetes, a Concise Presentation.* By Henry A. John, M.A., M.D., F.A.C.P. Published by C. V. Mosby Company, St. Louis 3, Missouri. 300 pages. Price \$3.25.

*Pneumoperitoneum Treatment.* By Andrew Ladislaus Banyai, M.D., F.A.C.P., F.C.C.P. Published by C. V. Mosby Company, St. Louis 3, Missouri. 376 pages, 74 illustrations. Price \$6.50.

*Diseases of the Retina.* By Herman Elwyn, M.D. Published by the Blakiston Company, Philadelphia. 593 pages, 170 illustrations. Price \$10.

*Narcotics and Drug Addiction.* By Erich Hesse, M.D. Published by the Philosophical Library, Inc., New York 16, New York. 219 pages. Price \$3.75.

## BOOK REVIEWS

*Cancer of the Colon and Rectum.* By Fred W. Rankin, B.A., M.A., M.D., L.L.D., Sc.D., F.A.C.S., surgeon, St. Joseph's and Good Samaritan Hospitals, Lexington, Kentucky, and A. Stephens Graham, M.D., M.S. (surgery), F.A.C.S., surgeon, Stuart Circle Hospital, Richmond, Virginia. Assistant professor of surgery, Medical College of Virginia. Published by Charles C. Thomas, Springfield, Illinois, 1945. 358 pages, 133 illustrations. Price \$5.50.

This is a well written and illustrated practical presentation of a condition commonly met with in the work of internist, surgeon, proctologist, general practitioner and gastro-enterologist. This work is not only for the general surgeon who mechanically attacks these growths but for all practitioners whose work concerns the terminal bowel.

The text is presented in three parts.

Part I, general considerations, embraces anatomy, physiology, pathology and symptomatology. Much of this is very well illustrated with drawings and reproductions of x-ray findings. The portion dealing with circulation, so important to successful surgery, is from original work by one of the authors.

Part II, treatment, covers operability, choice of operation, mortality, x-ray therapy and pre-and post-operative therapy. The vast personal experience of the authors together with the large bibliography makes this a valuable contribution.

Part III, operative procedures, again contains the valuable store of knowledge of the authors in their selection of the choice of mechanical procedure for these common growths of the colon and rectum.—*Leo A. Smith, M.D.*

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Often the cause of unexplained symptoms and signs arising from the urinary tract may be read like an open book when x-ray contrast is obtained with

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only by omitting something. It can't be done by a simple "acceleration of speech by a lecturer" and it may be suggested that neither can it be done by simply leaving out words by an author.

The best thing about the book, it seems to me, is that the author has attempted to organize the subject matter so that the physiology of the intact body is emphasized, a procedure which should aid very much in getting the reader to apply experimental data to the correct understanding of that which he observes in a patient. This is not to say that a discussion of the function of the parts of the body is avoided but they are discussed as parts of a whole. As further aids in this direction may be mentioned the rather frequent references to clinical examples to illustrate the discussion. This method of treatment is to my mind enough to justify the book, but I believe that its usefulness in this direction would have been much enhanced by employing more tables and diagrams. Another provision, especially appreciated in works of this kind, is to be found in the quite adequate index. The book is well bound, of convenient size, and is printed on good quality paper.—*Parke H. Woodard, M.D.*

\* \* \*

*The Modern Attack on Tuberculosis.* Revised Edition. By Henry D. Chadwick, M.D., and Alton S. Pope, M.D. Published by the Commonwealth Fund, 41 East 57th Street, New York City. 134 pages. Price \$1.00.

In offering a revision of the Chadwick-Pope book, the Commonwealth Fund is giving practical help to the whole field of tuberculosis effort. This little book of 130 pages has been found helpful because it is authoritative, from its first printing, at which time Doctor Chadwick had just completed his term as president of the National Tuberculosis Association.

The current edition is able to forecast "the goal of eradication—visualized in the distance," which means much coming from this conservative source. It predicts a death rate in the United States of 10 per hundred thousand in 1980 and thinks that "the bells that ring in the year 2000 may sound the death knell of the tubercle bacillus." The startling facts as to incidence of tuberculosis in the older age groups receive attention and there is an entire chapter on "A Community Campaign of Eradication," which is definite and specific as to the important steps.

This book is recommended not only to physicians but also to nurses and others responsible for the control of tuberculosis.—*C. H. Lerrigo, M.D.*

\* \* \*

*Skin Diseases in Children.* Second edition. By George M. MacKee, M.D., and Anthony Cipollaro, M.D., Published by Paul B. Hoeber, Inc., New York. 436 pages, 225 illustrations. Price \$7.50.

This well-edited and illustrated book fills a need long felt by the general practitioner, for whom it is chiefly written. Most of the skin diseases seen in children are also common to adolescents and adults, so that it can be used as a very practical text and reference book in dermatology. Diseases are conveniently grouped, partly etiologically, partly pathologically and partly on the basis of clinical similarity. The book has 436 pages and 225 very excellent illustrations, which are among the best seen in any textbook. The book is divided into 21 chapters with a complete bibliography at the end of each chapter. The chapters include: 1. Care of the Normal Skin, 2. Diseases in which Pyogenic Bacteria are Important, 3. Diseases due to Fungi, 4. Diseases due to Animal Parasites, 5. Allergic Dermatoses in Children, 6. The Eczema Group,

7. The Erythema Group, 8. Vascular Diseases, 9. Drug Eruption Group, 10. Scaling Dermatoses and the Lichens, 11. Benign and Malignant New Growths, 12. Congenital Cutaneous Anomalies, 13. Dystrophies, 14. Pigmentary Group, 15. Diseases of Sweat Glands, Sebaceous Glands, Hair and Nails, 16. Diseases of the Mouth, 17. Injuries due to Physical Agents, 18. Vesicular and Bullous Diseases, 19. Contagious Diseases, 20. Tuberculosis Group of Skin Diseases, 21. Syphilis in Children.

The chapters on allergic dermatoses (especially atopic eczema), tuberculosis and syphilis are outstanding. This book is especially practical for the general practitioner, who does not have the time to wade through a large volume. It can be used advantageously by medical students and nurses.—*Paul H. Hempill, M.D.*

\* \* \*

*Synopsis of Pathology.* Second Edition. By W. A. D. Anderson, M.A., M.D., F.A.C.P. Published by the C. V. Mosby Company, St. Louis. 741 pages, 327 illustrations, 15 colored plates. Price \$6.50.

This is a good pathology for the practitioner as it covers, to a certain extent, most pathological conditions. This edition enlarges on the subjects of tropical diseases, rickettsial and virus disease, as compared with the former edition. It is a condensed book, readable, with many very well selected illustrations. I am sure the book was intended more for the practitioner than the pathologist.—*J. L. Lattimore, M.D.*

\* \* \*

*Technical Methods for the Technician.* Third Edition. By Anson L. Brown, M.D. Published by B-B Printing Company, 329 South Fourth, Columbus, Ohio. 706 pages. Price \$10.

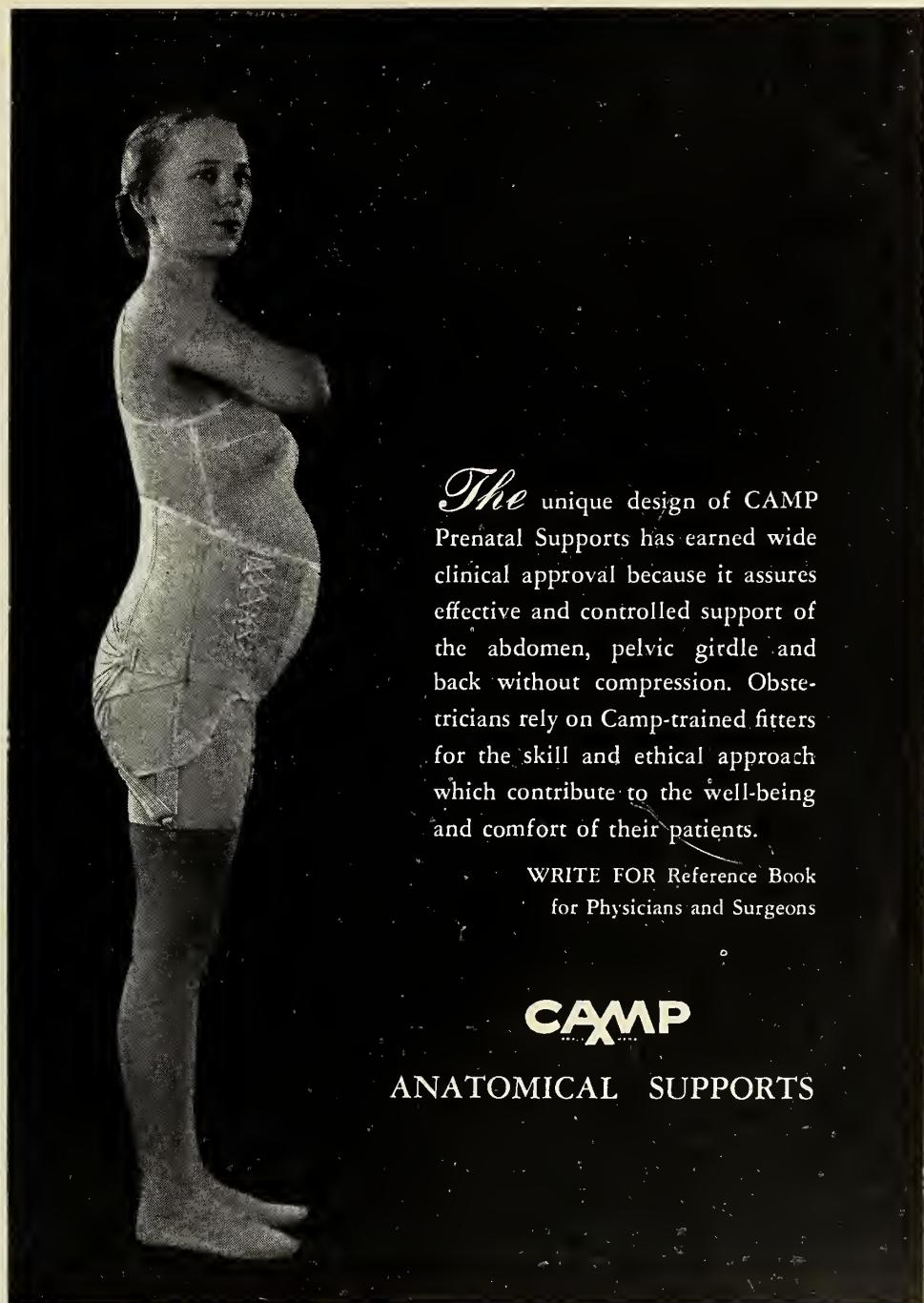
The book is a good reference text for procedures minus adequate theory explanation and interpretation of results, which the average technician should carry in mind to maintain interest in her work. It has many diagrammatic illustrations, useful laboratory charts, and outlines for setting up equipment for the various procedures; but on the whole, it impresses the reviewer as being personalized to the extent of "boredom" in places.

For the student technician who has not had the necessary college preparation for her work, the book would be a useful guide. It does not burden her with technicalities. For the graduate technician who has her college and training degrees, it would serve as a procedure reference text, although there is very little new in it.—*Ollie Wilson, M.T.*

\* \* \*

*Hay Fever Plants.* By Roger P. Wodehouse, Ph.D. Published by the Chronica Botanica Company, Waltham, Massachusetts; agent, G. E. Stechert and Company, 31 East 10th Street, New York City. Copyright 1945. 245 pages. Price \$4.75.

This book is written by Roger P. Wodehouse who is one of the best living authorities on the study of plants in their relationship to hay fever. It is a very complete presentation on every phase of the subject, going into detail in the structure of the plants and especially in the morphology of their pollen grains. It also presents a survey of all sections of the United States, giving the important pollens in each section and time of pollination. It is a valuable book for anyone devoting much of his time to the treatment of pollenosis.—*Vernon C. Wiksten, M.D., F.A.C.A.*



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*The Human Mind.* 1945 Edition. By Karl A. Menninger, M.D. Copyright 1945. 517 pages. Price \$5.00. Published by Alfred A. Knopf, New York, New York.

This book, which has become almost a standard hearth-side utility in the American scene, is one which rightly deserves its place. Writing to the reader, instead of *at* him, Doctor Menninger presents his subject as living, dynamic force which is present in every nook and cranny of our complex everyday life. The author does not write in words of one syllable but one is not aware of this until the book is finished and in retrospect the reader is brought face to face with having just swallowed a very complicated subject and having it pass the cario-esophageal junction without a hitch.

The method by which Doctor Menninger is able to achieve this blandness is at once ingenious as well as deft. His reader is his patient and he uses all the guiles and art of the psychiatrist well versed and adept in the art of human relationships. He approaches the reader upon the latter's own terms and thereby captivates him without compromise. Besides the lucid exposition, there is an abundance of case material, journalistic and literary quotations and illustrative experiences to brighten any didactic dull spots.

The book is separated into seven sections. The first and last of the six chapters are perhaps the most important from the standpoint of where psychiatry has been and where it is going. The former concerns conceptions of mind and health; the latter, "extensions of psychiatric theory." Among these, as most of us are becoming aware, are education, industry, law (including delinquency, the theory of punishment and criminality), religion and medicine. Other sections deal with basic personality types, symptoms, motives in human behavior and treatment.

As you have discerned from the above, this book is not for the professional alone. It is meant and written for anyone who deals with human problems, such as the school teacher, the social worker, personnel of law enforcement agencies and, in the last analysis, each one of us.

For who is there among us that does not fulfill the proverbial conditions of stone casting? Most of all, it should be a helpful work to the general practitioner or specialist in order to understand the holistic theory "which simply means that physical, chemical, and psychological aspects of personality must all be considered for a useful scientific evaluation of the 'total personality.' The practical inference of this for the physician is that all physical diseases have psychological elements which must be considered in both diagnosis and treatment."—Irving N. Baer, M.D.

Physical fitness is a worthy objective for the laity and the medical profession alike. Every activity that favors physical and muscular development merits support. On the other hand, man has his intellectual, moral and spiritual side in addition to his physical side. The youth movement in Germany was highly successful in developing the physical fitness of her young men and women. Lack of emphasis, however, on the moral and spiritual needs of her people has resulted in tragedy for Germany and the rest of the world.—Ed., Minn. Med., Dec., 1944.



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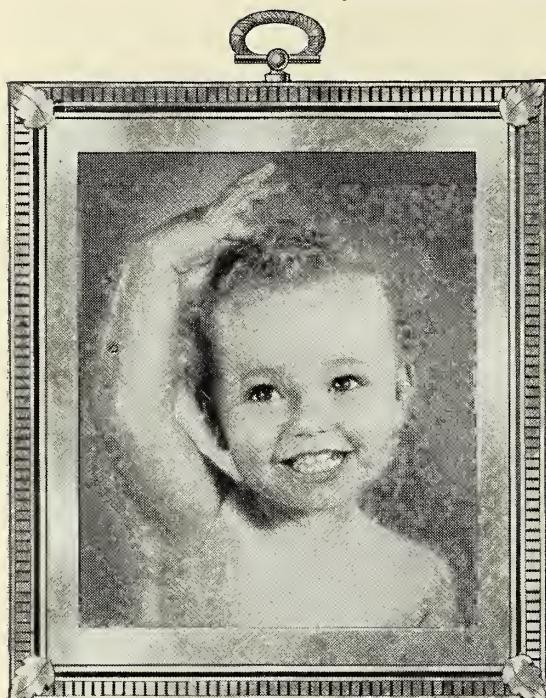
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### THE EARLY DIAGNOSIS OF DISEASES OF THE CHEST

(Continued from Page 303)

carcinoma of the lung, physical signs are extremely unreliable and at best only suggestive.

Roentgenologic study of the chest should be a routine procedure in the examination of every patient admitted to hospitals and institutions. In the light of present knowledge, routine roentgenologic study of the chest is at least four times as important as blood cell counts, urinalysis or other routine procedures now in use. It also serves to protect patients and hospital personnel against the unsuspected active cases of tuberculosis that are constantly present in hospitals. Fluoroscopy or photofluorography require little time and can be done at a cost of only a few cents a patient.

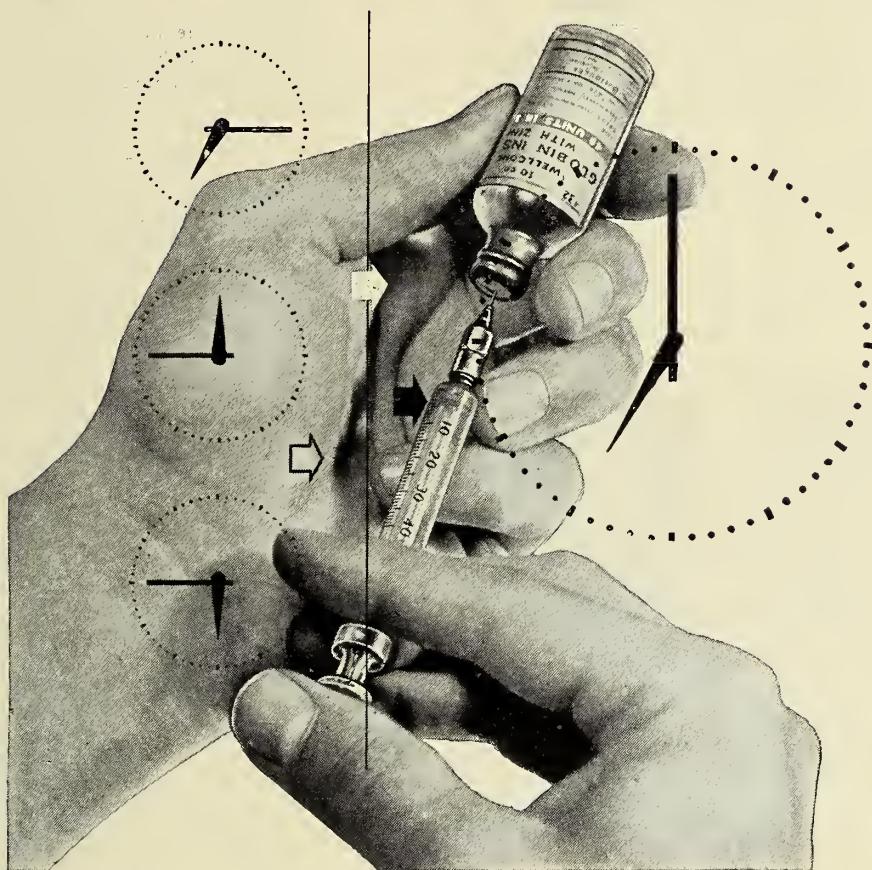
In every patient suspected of having tuberculosis careful sputum studies should be performed in an attempt to confirm the diagnosis. To avoid delay, the use of routine smears should be avoided. These smears are so unreliable that a negative result is meaningless. Three consecutive seventy-two hour pooled sputum specimens should be concentrated. If they are negative on microscopic examination, the sediment should be cultured and inoculated into guinea pigs, and three consecutive gastric lavages examined immediately by the concentration method. Acid-fast bacilli found in gastric lavages when the sputum is negative should always be cultured and inoculated into a guinea pig to identify the acid-fast bacilli as tubercle bacilli. When these tests are repeatedly negative in a patient with a demonstrable parenchymal infiltration in the lung that is apparently active, the lesion is probably non-tuberculous, and other diagnostic procedures are indicated.

Any patient with a visible tumor or an unexplained density or suppuration in the lung, especially if he is in the middle or older age group, should be suspected of having a pulmonary cancer. Such patients should be bronchoscopy immediately; 60 to 70 per cent of bronchiogenic carcinomas originate in the major bronchi, and a biopsy specimen to establish the diagnosis can be obtained.

Surgical exploration of the chest is a safe procedure, and should be utilized more frequently to determine the etiology of unexplained pulmonary lesions. Aspiration biopsy is used to secure tissue for pathologic study only in cases that are obviously inoperable. In patients in whom operation is possible, exploration is safer and more accurate.

The responsibility for the early apprehension of pulmonary disease rests largely on the shoulders of the general practitioner and the internist, since they are the first to see the patient. Their offices should and can be the greatest case-finding agencies in the

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entire field of medical practice. To make this possible, the limitations of the history, the physical examination and certain laboratory procedures must be more keenly appreciated, and rigid diagnostic procedures must be applied routinely.—*The Early Diagnosis of Disease of the Chest, Normal J. Wilson, M.D., New England Jour. of Med. March 15, 1945.*

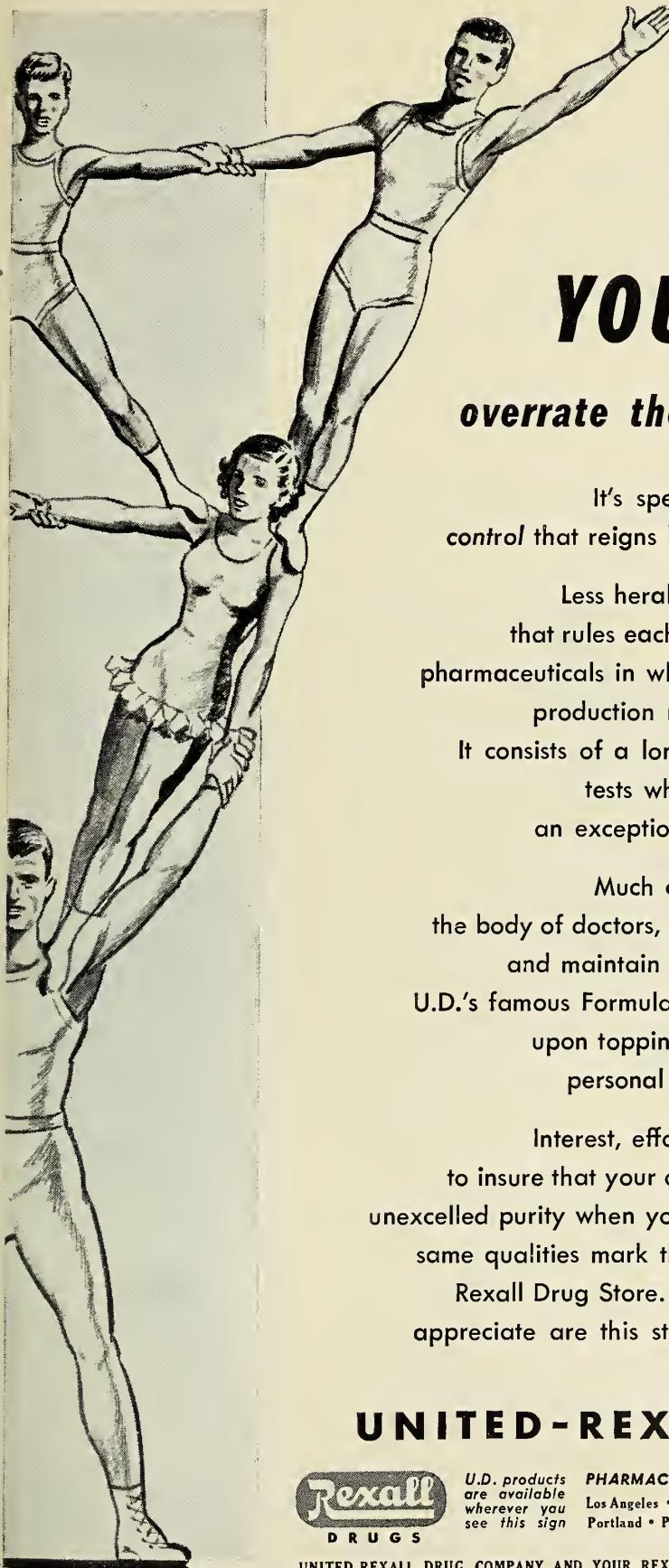
It is claimed that the use and misuse of laxatives is probably responsible for the development of hemorrhoids as frequently as any other single factor.—Ellis Moore, M.D., in the Journal of the Oklahoma State Medical Association.

We can conclude that with the present state of our knowledge, malignant disease is most probably the result of some form of carcinogenic substance, either arising within the body or applied from the outside. There is absolutely no evidence that a malignant tumor arises from a single trauma. On the other hand, trauma may result in a chronic discharging sinus or chronic ulceration, which eventually may be the site of a malignant growth. In such a case the trauma alone is not the cause of the growth, but the trauma produced certain changes in the tissues, which in turn produced certain chemicals, or endogenous carcinogenic substances, which are the real cause of the growth.—A. K. Harcourt, M.D., and Jewett V. Reed, M.D., in the Journal of the Indiana State Medical Association, January 1946.

In cases of renal colic, the best interest of the patient is served by making a thorough urologic investigation to determine the cause so that the necessary steps can be taken to prevent possible later insidious renal damage. Intravenous urography during the attack is sometimes helpful in establishing the nature of the responsible lesion. Nonfibrous obstruction at the vesical end of the ureter may exist even though it is possible to pass catheters through this portion of the ureter.—James F. McCahey, M.D., in the Pennsylvania Medical Journal.

The channels through which information about new scientific developments flows are direct and dependable. When a research worker has completed a project, he submits a report to the editors of one of the many medical and scientific journals, and usually publication of the results of his work follows within a few months. This enables other research workers and physicians to utilize promptly any of these new facts either in treatment of patients or in the development of new scientific information. The prompt publication of results is an ethical responsibility of the scientist to aid others engaged in similar problems. No one need fear that he will be denied any valuable secret remedy.

Newspaper reporters and authors of magazine articles recognize the news value of scientific discoveries. Occasionally they use sources of information less authoritative than those of established medical journals, to the chagrin of research workers and to the confusion of patients. Human lives may be lost needlessly if patients who have tuberculosis choose to forsake or refuse well-established methods of treatment in the hope of receiving remedies inadequately tried or of unproved effectiveness.—*Chemotherapy in Tuberculosis, H. C. Hinshaw, M. D., and William H. Feldman, D. V. M., The NTA Bulletin, Oct. 1945.*



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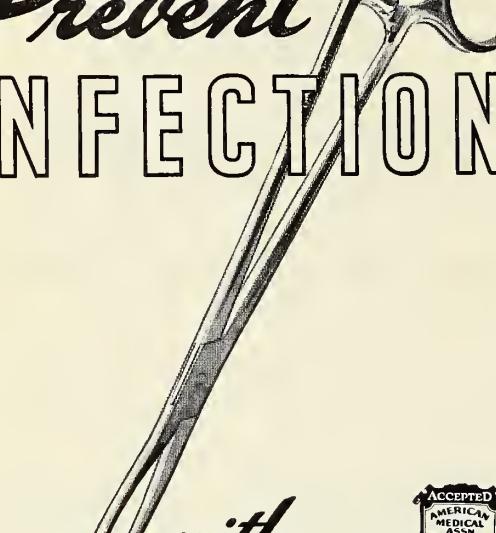


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## ANNOUNCEMENTS

The Rocky Mountain Radiological Society announces its mid-summer radiological conference to be held in Denver August 8-10, 1946. Guest speakers on the program are Doctors John Camp, William E. Costolow, Ross Golden and Dabney Kerr. All physicians interested in radiology are invited to attend.

The American Congress of Physical Medicine will hold its 24th annual scientific and clinical session at the Hotel Pennsylvania, New York, September 4-7, inclusive. Complete information may be secured from the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

The Inter-American Congress of Radiology will be held at Havana, November 17-23, 1946. Reservations may be made through the American College of Radiology, 20 North Wacker Drive, Chicago 6, Illinois.

The Veterans Administration Medical Service Center, 518 New England Building, Topeka, Kansas, announces its telephone number for the convenience of physicians who have occasion to call. The number is 2-9319.

The 24th annual fall conference of the Kansas City Southwest Clinical Society will be held at Kansas City, October 7-10, 1946. A list of guest speakers and the complete program will be announced later.

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Volume XLVII

AUGUST, 1946

Number 8

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## Roster of Members of Kansas Medical Society

Because of the war and the disruption of doctors of medicine, the American Medical Association has not revised its directory since 1942. The Kansas Medical Society has recently received so many requests from its membership concerning the location of doctors that the Editorial Board determined to publish this roster.

Below are listed all members of the Kansas Medical Society and their locations, as of July 20, 1946. Since this represents the information available at the central office, the Kansas Medical Society will welcome corrections for any errors that may be found.

### LISTED ALPHABETICALLY

#### A

Abrams, William W.	Kansas City
Abramson, William Frederick	Topeka
Adams, Alonzo Roy	Brownsville, Tex.
Adams, Austin Justus	Topeka
Adams, Charles Samuel	St. John
Adams, James Harlan	Wichita
Adamson, Adam Hancock	Arcadia
Albaugh, Houghton Samuel	Olathe
Albright, Fred Clayton	Garland
Alderson, Clair Milton	Dodge City
Aldis, John	Council Grove
Alexander, Clyde William	Kansas City
Alexander, Xeno Frederic	Dodge City
Algie, William Hackney	Kansas City
Allen, Frances Ann	Newton
Allen, George Viven	Topeka
Allen, Lewis George	Kansas City
Allen, Max Scott	Kansas City
Anderson, Arthur Sam	Lawrence
Anderson, Bert	Victoria
Anderson, Cornelius Oscar	Concordia
Anderson, Donald Andrew	Salina
Anderson, Harry Oscar	Wichita
Anderson, Jeff Turner	Leavenworth
Anderson, John Bradley	Valley Falls
Anderson, Robert Caroden	Topeka
Anderson, Samuel Milligan	Wichita
Anderson, Severt Andrew	Clay Center
Anderson, Winstan L.	Atchison
Andreson, Paul Sanford	Sylvan Grove
Andrews, William Wallace	Kansas City
Angle, Lewis Winston	Kansas City
Antony, Arthur Charles	Clyde
Antrim, Philip Jenifer	Birmingham, Ala.
Armantrout, Leonard Otho	Garden City
Armitage, Albert Constant	Hutchinson
Armstrong, Carroll Dunham	Salina
Armstrong, Carroll William	Salina

Asbell, Edward Lawrence	Kansas City
Ashley, Byron John	Topeka
Ashley, George Lee Roy	Chanute
Ashley, Samuel Glick	Chanute
Ashmore, Arthur Lawrence	Wichita
Athy, Gregg Barr	Columbus
Atkin, Edward Henry, Jr.	Hoisington
Attwood, George Arthur	Randolph
Attwood, John Edward	LaCrosse
Auchard, Virgil Marion	Lawrence

#### B

Badger, Edward Bruce	Omaha, Nebr.
Baer, Daniel C.	Mound Ridge
Bagby, Harold James	Coffeyville
Bailey, Sanford	Garden City
Baird, Albert Clark	Parsons
Baird, Cecil Dryden	Eureka
Baird, Jay	Coffeyville
Baker, Elven O.	Wichita
Baldridge, Richard Edwin	Kingman
Bale, George Winfred	Clay Center
Ball, Ralph Garnett	Manhattan
Ballard, Marshall Paul	Delphos
Bandy, Claudius Estyl	Bucklin
Banteon, Verne Henry	Kansas City
Barker, John Ethan	Kansas City
Barnard, Ruth I.	Topeka
Barnes, Conrad Marden	Seneca
Barnes, Harold Reuben	Hutchinson
Barney, Louis Frank	Kansas City
Barr, John Franklin	Ottawa
Barry, William Burnett	Kansas City
Bartlett, Wayne Chrispian	Wichita
Bascom, Kellogg Finley	Manhattan
Basham, Charles Edward	Los Angeles, Calif.
Basham, Francis Claybourne	Eureka
Basham, James Joseph	Eureka
Basham, John Henry	Eureka
Bass, Lewis Napier	Pittsburg

Bates, Gerald Chapman	Independence	Bowen, William Francis	Topeka
Baty, Fred Daniel	Liberal	Bowman, Lang Fulton	Wichita
Bauman, Menford Leon	Parsons	Bowser, John Francis	Kansas City
Beal, B. Clyde	Clearwater	Boyd, Charles Arthur	Hutchinson
Beal, Lynn Elwood	Fredonia	Boyd, Spencer Harwood	Topeka
Beal, Raymond Jameson	Fredonia	Boyden, Mary Scarborough	Lawrence
Beam, Albert	Americus	Brady, Charles Stuart	Atchison
Beasley, Charles Wesley	Lyndon	Braithwaite, Harold Musgrave	Kansas City
Beauchamp, Preston Earl	Sterling	Brakebill, Martin Luther	Sharon Springs
Beaver, James Leland	Wichita	Braun, William Thomas	Pittsburg
Becker, Richard Robert	Kansas City, Mo.	Brawley, Mark Abernathy	Frankfort
Beckner, Ernest Jones	El Dorado	Bienemann, Frederick Strauffer	Hesston
Beebe, Edmer	Olathe	Brenneman, Jacob James	Mound Ridge
Beeler, Canada Asbery	Cherryvale	Bresette, Louis Lafe	Kansas City
Beelman, Floyd Cornelius	Topeka	Bressler, Alexander Hodge	Wamego
Beiderwell, Earl Reade	Garden City	Brethour, George Edwin	Dwight
Beiderwell, Paul Leo	Belleville	Brethour, Leslie J.	Junction City
Belknap, Paul Edward	Topeka	Brewer, William McKelvey	Hays
Bell, Cleo D.	Pittsburg	Brian, Robert Milling	El Dorado
Bell, Perry Marshall	Wichita	Bribach, Eugene John	Atchison
Beller, Willis Leon	Topeka	Brier, Archibald John	Topeka
Belot, Monti Louis, Jr.	Lawrence	Brittain, Oman Reuben	Salina
Bena, James Henry	Pittsburg	Bronson, Dellett Emory	Olathe
Benage, Clarence Harrison	Pittsburg	Brooks, Edgar Ernest	Burden
Bence, Arthur Edgar	Wichita	Brown, Caroline Christel	Kansas City
Benitz, George William	Wathena	Brown, Cyril Carroll	Wichita
Bennett, Charles Alvin	Leavenworth	Brown, Harry Clinton	Stockton
Bennett, Richmond Eugene	Beloit	Brown, Harwin Joseph	Winfield
Bennie, Herbert Stewart	Almena	Brown, Manuel Jay	Salina
Berger, John Philip	Wichita	Brown, Porter	Salina
Berggren, Andrew Leon	Chetopa	Brown, Thomas Jacob	Hoisington
Bernstorf, Warren Frederick	Winfield	Brown, Virgil Evan	Sabetha
Bestgen, Fred Peter	Manhattan	Brown, William	Paola
Bethauser, Joseph Rudolph	Hays	Browne, Herbert Andrew	Galena
Betz, John Sherrill	Kansas City	Brownell, Morton Emmons	Wichita
Beverley, George William B.	Topeka	Brownlee, John James	Hutchinson
Beverly, Squire S.	Rutland Heights, Mass.	Brungardt, Balthaser Aloysius	Salina
Beyer, Louie John	Lyons	Brunner, Benjamin, Jr.	Wamego
Bierlein, Kenneth John	Pittsburg	Bryan, Emery Clarence	Erie
Biermann, Aloysius Henry	Garden Plain	Bryan, Harry Raymond	Hays
Biermann, William John	Wichita	Buck, Ben H., Jr.	Wichita
Billings, Alva Edgar	Topeka	Buckmaster, Francis Henry	Elkhart
Billingsley, John A.	Kansas City	Bula, Ralph Elmer	Lyons
Bishoff, Mark Lincoln	Topeka	Buley, Delmond Gilbert	Sedgwick
Bitzer, Donald A.	Washington	Bullock, Harold Oliver	Independence
Black, Cyril Victor	Pratt	Buooa, Fern Ward	Mulvane
Blackburn, Lewis Claude	Eudora	Burger, Julius Anthony	Kansas City
Blair, William Francis	San Antonio, Tex.	Burket, George Edward, Jr.	Kingman
Blake, Clyde Dale	Hays	Burket, Ivan Roy	Ashland
Blake, Clyde Dale, Jr.	Hays	Burkett, Norman Andrew	Newton
Blake, Henry Seavey	Topeka	Burkhead, Carl Roscoe	Wichita
Blank, John Nicholas	Hutchinson	Burnett, Ferd	Cunningham
Blasdel, Harry Emer	Hutchinson	Burnett, James Robinet	Caldwell
Blasdel, Tyler David	Parsons	Burns, Warren Whitcomb	Manhattan
Blount, Justin Alexander	Larned	Burtch, Claude Elijah	Portis
Blount, William Marshall	Kansas City	Busch, Anthony Bering	Dodge City
Boese, Adolph	Coffeyville	Busenbark, Ray	Kansas City
Bogan, Harvel Lewis	Baxter Springs	Butcher, Archie William	Wakefield
Boggs, Frank Clinton	Topeka	Butcher, Thomas Peck	Emporia
Boltjes, Ben Harold	Philadelphia, Pa.	Butin, James Abram	Chanute
Bolton, Dan W.	Frankfort	Butler, Joseph Payne	Coffeyville
Boone, Abner Eugene	Kansas City	Butler, William Lucas	Stafford
Borst, William Lewis	Topeka	Bux, Donald Eugene	Columbus
Bosse, Frank Krenning	Atchison	C	
Boswell, James Henry	Baxter Springs	Caldwell, John Cook	Wellington
Boudreau, Clarence Edwin	El Dorado	Calhoun, Fred	Sedan
Bowen, Clovis Walker	Topeka	Calkins, LeRoy Adelbert	Kansas City
Bowen, Harry Justus, Jr.	Topeka	Callahan, William Paul	Wichita
Bowen, James Dinwiddie	Topeka	Campbell, Charles Albert	Kansas City

Campbell, Charles Samuel .....	Coffeyville	Colt, James Dennison, Jr. ....	Manhattan
Campbell, Garland Leroy .....	Wichita	Colt, James Dennison, Sr. ....	Manhattan
Campbell, John Ross .....	Pratt	Colt, James Dennison, V .....	Manhattan
Campbell, Robert Finley .....	Iola	Combs, George Ralph .....	Leavenworth
Canuteson, Ralph Irving .....	Lawrence	Conard, Richard F. ....	Baxter Springs
Capps, Murl T. ....	Emporia	Condon, Albert Paul .....	Atchison
Carbaugh, Kenneth Wayne .....	Mission	Cone, Luther Hose .....	Chanute
Carey, Francis Stephen .....	Kansas City	Conklin, Kenneth Eugene .....	Abilene
Carlson, Marlin Winthrop .....	Ellinwood	Conklin, Quinton Dieter .....	Abilene
Carlsson, Erland Robert .....	Winfield	Conklin, Tracy Roscoe, Jr. ....	Abilene
Carr, David Decatur .....	Topeka	Conley, James George .....	Pittsburg
Carr, Robert Manning .....	Junction City	Contad, Paul Edgar .....	Hiawatha
Carr, Walter Austin .....	Junction City	Conroy, John Colin .....	Arwood
Carreau, Ernest R. ....	Mulvane	Conwell, Daniel Vincent .....	Wichita
Carson, Paul Congleton .....	Wichita	Coon, William Franklin .....	Caney
Carter, Earl Dwight .....	Wichita	Cooper, Arthur Edwin .....	Norton
Carter, John Nicholas .....	Garnett	Cooper, Everett Lucius .....	Wichita
Carter, Jonathon Basil .....	Denver, Colo.	Cooper, Lawrence Leon .....	Fort Scott
Carter, Rodney Gilbert .....	Independence	Corbett, Arthur William .....	Emporia
Casto, James Frederick .....	Topeka	Corbett, Oliver John .....	Emporia
Cavanaugh, John W. ....	Topeka	Cordonier, Alfred Edward .....	Troy
Cave, Fred Clifford .....	Oxford	Corrigan, George Francis .....	Wichita
Cave, Robert Russell .....	Manhattan	Coughlin, Samuel Thomas .....	Larned
Cazier, Lawrence Wallace .....	Wamego	Cowden, Alva Lemon .....	Pittsburg
Chadwick, Ira Bradford .....	Coffeyville	Cowles, George Edwin .....	Wichita
Chaffee, Spencer Norman .....	Solomon	Cox, Seth Leroy .....	Topeka
Chambers, Adelbert Royal .....	Iola	Cox, Wilfred .....	Wichita
Chambers, Harry Leslie .....	Lawrence	Coyle, Emery Golden .....	Coffeyville
Chapman, Florence P. Simms .....	Topeka	Crabb, John Adam .....	Topeka
Chappell, Ewin Summers .....	Topeka	Craig, Alexander Crawford .....	Topeka
Cheney, James William .....	Wichita	Cramer, Guy William .....	Parsons
Cheney, Ralph Edwin .....	Salina	Cramm, Carl John .....	Russell
Chesky, Victor Ernest .....	Halstead	Crank, Henry Harlan .....	Topeka
Chickering, George Abbot .....	Hutchinson	Crews, Cora Snyder .....	Hiawatha
Chipps, James Edward .....	Wichita	Crittenden, Alden Larue .....	Wichita
Chont, Laslo Kendey .....	Winfield	Croson, Franklin Roy .....	Clay Center
Choy, James King Lee .....	Topeka	Cross, James Willboarn S. ....	Portis
Christian, Robert Ord .....	Iola	Crow, Ernest Whitaker .....	Wichita
Christmann, Marshall E. ....	Pratt	Crumpler, Leo Kyle .....	Wichita
Christmann, Paul .....	Wichita	Currie, William Ebenezer .....	Sterling
Church, Harry Lester .....	Pittsburg	Curry, Lewis Allison .....	Topeka
Clapp, Raymond Carlton, Jr. ....	Wichita	Curtis, Howard Crosby .....	Nashville, Tenn.
Clark, Earl Finley .....	Belle Plaine	D	
Clark, Herbert Lee .....	Topeka	Danielson, Arthur David .....	Herington
Clark, Howard Charles .....	Wichita	Daugherty, Robert Melvin .....	Meade
Clark, John Donavan .....	Wichita	Davidson, Harry Thomas .....	Wichita
Clark, Margaret Goode .....	Lawrence	Davidson, Oscar Wilford .....	Kansas City
Clark, Orville Richolson .....	Topeka	Davies, Edward Idris .....	Clay Center
Clark, Porter M., Jr. ....	Independence	Davis, Christopher Gates .....	Kansas City
Clark, Ray Albert .....	Lawrence	Davis, David Richard .....	Emporia
Clarkson, William Henry .....	Manhattan	Davis, Donald Ray .....	Dodge City
Claypool, John Gordon .....	Kansas City	Davis, George Fred .....	Kanopolis
Clayton, Emanuel Harry .....	Arkansas City	Davis, George William, Jr. ....	Kansas City
Clayton, Ione Schultz .....	Arkansas City	Davis, Harry Joseph .....	Topeka
Clossen, Harold Otis .....	San Francisco, Calif.	Davis, Harry William .....	Plains
Cloyes, Arthur Pearson .....	El Dorado	Davis, Paul Edward .....	Parsons
Clutz, Ralph R. ....	Bendena	Day, Hughes Winfield .....	Kansas City
Coady, Charles Cromer .....	Kansas City	Deal, Edwin Perle .....	Greensburg
Cobean, Harry Lester .....	Wellington	Dean, George Roland .....	McPherson
Coburn, Clay Ephraim .....	Kansas City	Dechairo, Thomas .....	Westmoreland
Cochran, Athol .....	Pratt	Decker, Ernest Hamilton .....	Topeka
Coffey, Frank Ellsworth .....	Hays	Deeths, Harry J. ....	Atchison
Coffin, Benjamin F. ....	Kansas City	Delp, Mahlon Henry .....	Kansas City
Coffman, Francis Marion .....	Ford	DeMand, John Wesley .....	Lincolnville
Coffman, John Franklin .....	Wichita	DePew, Frank L. ....	Howard
Cohen, Louis .....	Topeka	DeVilbiss, Edgar Frank .....	Kansas City, Mo.
Cole, Ward Martin .....	Wellington	Dewey, Charles Homer .....	Camp Robinson, Ark.
Coleman, John Spurgeon .....	Wichita	Dickinson, Jasper Myrton .....	Coffeyville
Collins, Harold Lesley .....	Beloit	Dickson, Ross Dale .....	Topeka

Diefendorf, Donald Mace	Waterville	Pittsburg
Dieter, Charles August	Harper	Wichita
Dieter, Johann Nickaulaus	Abilene	Kansas City
Dildine, Arthur Royal	Cheney	
Dillenbeck, Floyd Earl	El Dorado	F
Dillon, John Alfred	Larned	
Dillon, Tony Guy	Kansas City	Pittsburg
Dingus, Allen Cedar	Yates Center	Inglewood, Calif.
Dittemore, James Henry	Belleville	Osawatomie
Dixon, Charles Hall	Wichita	Winfield
Dodge, Mark	Salina	Topeka
Donnell, Louis August	Wichita	Wichita
Dorsey, Dennis Basil	Lawrence	Atchison
Douglas, Harry Leonard	Kansas City, Mo.	Kansas City
Dowler, Vernon Booth	Dodge City	Hutchinson
Drake, Ralph Lafayette	Wichita	Louisburg
Dreher, Henry Samuel	Salina	Concordia
Dreher, Henry Samuel, Jr.	Kansas City	McPherson
Drisko, Robert Marshall	New York, N. Y.	Topeka
Druet, Kenneth Lewis	El Paso, Tex.	Paola
Duckett, Thomas Gaillard	Hiawatha	Wichita
Dunbar, Milton James	Winfield	Kansas City
Duncan, Edgar Cecil	Fredonia	Hutchinson
Dunlap, Richard Leonidas	Topeka	Fredonia
Dwiggins, Frank Pierre	Houston, Tex.	Selden
Dyck, Arthur Hertzler	McPherson	Onaga
Dyck, Cora Elizabeth	Mound Ridge	Kansas City
Dyer, Benjamin George	Kalamazoo, Mich.	Topeka
Dyer, William Holmes	Kansas City	Independence
Dysart, Jack Carl	Sterling	Hutchinson
<b>E</b>		
Earp, Ralph Bowman	El Dorado	Emporia
Eaton, Leslie Fay	Salina	Emporia
Ebert, Adam John	Oswego	Topeka
Eckart, De Merle Emery	Abilene	Hutchinson
Eckdall, Frank Albert	Emporia	Halstead
Eckdall, Funston J.	Emporia	Minneapolis
Eckles, Lucius Elkanah	Topeka	Osawatomie
Eddy, Murray Chadwick	Hays	Osawatomie
Eddy, Victor Cooper	Colby	New York, N. Y.
Edgerton, Erastus Smith	Wichita	Kansas City
Edmiston, Roy Hammond	Lawrence	Larned
Edmonds, George Marius	Horton	Kansas City, Mo.
Edmonds, Leland Creason	Horton	Colorado Springs, Colo.
Edwards, Elva Elton	Allen	Greensburg
Edwards, Estella Mae	Cedar Vale	Wichita
Edwards, James Francis	Santa Ana, Calif.	Delia
Eggleston, Donald Edwin	Macon, Mo.	Osage City
Eitzen, Abraham Clement	Hillsboro	Wichita
Elkins, William Harry	Topeka	Wichita
Ellis, Ralph Carlisle	Cleveland, Ohio	Columbus
Ellis, Stephen Stuart	Coffeyville	Kansas City
Elnen, Walter Thomas	Wichita	Topeka
Elson, Vervil J.	Paola	Topeka
Embry, Horace Crandell	Great Bend	Independence
Emerson, Ralph Waldo	Topeka	G
Emery, Frank Addison C.	Wichita	Anthony
Emery, William Gordon	Barnard	Hugoton
Enders, Edwin Wray	Kansas City	Salina
Enns, Jacob Harlow	Newton	Wichita
Ensign, Paul Roselle	Topeka	Iola
Epp, Frederic Oliver	Valley Falls	Chanute
Erickson, Clarence Wilber	Pittsburg	Augusta
Erickson, Oscar Leonard	Topeka	Cherryvale
Ernest, Elvenor Ann	Topeka	Louisburg
Evans, Arthur Wilbur	Pueblo, Colo.	Ellinwood
Evans, Darrel Lee	Manhattan	Leavenworth
Evans, Ellis Austin	Conway Springs	Wichita
Evans, Farris De Vol	Camp Chaffee, Ark.	Concordia

Gench, Raymond Lane .....	Fort Scott	Haines, Chester Wayne .....	Haven
Gertson, Emery Talmage .....	Atwood	Hall, Clarence Walter .....	Hutchinson
Gill, George Laurance .....	Sterling	Hall, Frederic Wilhelm .....	Winfield
Gill, John Montgomery .....	Kansas City	Hall, Millard Wilson .....	Pasadena, Calif.
Gill, Merton Max .....	Topeka	Hamill, Claude Emmett .....	Parsons
Gillet, Wilbur Goodson .....	Wichita	Hamilton, Tom Reid .....	Kansas City
Gilliland, James Orth .....	Herington	Hammel, George Wesley .....	Hoxie
Gish, George J. P. ....	Frontenac	Hammel, Seth A. ....	Topeka
Glaser, Leland Forrest .....	Hutchinson	Hancks, John Achabod .....	Wamego
Glassen, Mary T. DeMotte .....	Phillipsburg	Hardesty, Henry Osmond .....	Jennings
Glauner, Frederick Earl .....	Topeka	Harms, Albert Charles .....	Kansas City
Gleason, Kenneth Jack .....	Independence	Harner, Romeo Catlin .....	Howard
Glenn, Lyle George .....	Protection	Harp, Robert Franklin .....	Highland
Glover, Harold Mortimer .....	Newton	Harrison, Charles Frederick .....	Syracuse
Gloyne, Louis Boucher .....	Kansas City	Hartig, Otto Joseph .....	Downs
Goldblatt, Bernard .....	Kansas City	Hartman, Buford .....	Kensington
Gollier, Charles Edward .....	Independence	Hartman, William Vernon .....	Pittsburg
Gollier, Robert Addison .....	Ottawa	Harvey, Ernest Edward .....	Salina
Gomel, Ray Gaffney .....	Washington	Harvey, Fredric Everett .....	Minneapolis
Gooch, William S. ....	Fort Scott	Harvey, John King .....	Salina
Goodlos, Hart .....	Independence	Haskins, Henry Edgar .....	Kingman
Goodsheller, George Jaroslav .....	Marion	Hassig, Cecil Edward .....	Kansas City
Gootee, Herbert William .....	Topeka	Hassig, John Franklin .....	Kansas City
Gordon, William George .....	Kansas City, Mo.	Hastings, Grant Ray .....	Garden City
Goshorn, Herbert Renner .....	Alton	Hatcher, Albert Rudolph .....	Wellington
Gouldner, René M. ....	Wichita	Hatfield, William J. ....	Topeka
Gradinger, Billens C. ....	Halstead	Hatton, Lloyd William .....	Salina
Granger, Wayne Bernard .....	Emporia	Haughey, Charles Francis .....	Anthony
Graves, Louis Greene .....	St. John	Haughey, George Cornelius .....	Prescott
Gray, Albert Newton .....	Burlington	Haughey, Leo Eugene .....	Concordia
Gray, George Morris .....	Kansas City	Haus, Loren Wilson .....	Kansas City
Gray, Harry Palmore .....	Seneca	Havley, Bernice Gorsuch .....	Centralia
Grayson, Roy David .....	Overland Park	Hawes, Frederick Sears .....	Russell
Green, David E. ....	Pleasanton	Hawke, Charles Clifford .....	Winfield
Green, John Dryer .....	McPherson	Hawkey, Alfred Samuel .....	Newton
Green, Will James .....	Cambridge	Hawkins, Robert .....	Marysville
Greenlee, Guilford Glenwood .....	Chapman	Haworth, Edgar Sylvester .....	Wichita
Greenwood, Edward David .....	Topeka	Haworth, Kenneth Walden .....	Menlo Park, Calif.
Greer, Richard Henry .....	Topeka	Hay, Gilbert Wilson .....	Parsons
Greever, Boyd Lorens .....	Hutchinson	Hayden, Abigail .....	Fredonia
Greider, William Henry .....	Tulsa, Okla.	Hayes, Harry James .....	Topeka
Gribble, Robert C. ....	Dodge City	Haynes, Arthur Haislet .....	Sabetha
Grieve, George Harry .....	Turon	Hays, Almona Deaver .....	Cherokee
Grigsby, Clement E. ....	Coffeyville	Hays, Leslie Claire .....	Cedar Vale
Grigsby, Kenneth Raymond .....	Medicine Lodge	Heaston, William Chamlis .....	McPherson
Gripkey, Clarence Anthony .....	Kansas City	Heasty, Robert George .....	Manhattan
Grissom, Calton Barney .....	Syracuse	Heckart, Elliott Tate .....	Topeka
Grosdidier, Edward Joseph .....	Kansas City	Hedge, Mayro Oran .....	Kansas City
Grosjean, Wendell Andrew .....	Winfield	Heins, Lawrence Gustavus .....	Abilene
Grove, John Axtell .....	Newton	Hellweg, Edward Walter .....	Arkansas City
Grove, John Leon .....	Newton	Hellwig, Christian Alexander .....	Wichita
Grove, William Edward .....	Newton	Helwig, George Freeman .....	Topeka
Grove, William Thomas .....	Eureka	Hempstid, Irl Edwin .....	Hutchinson
Gsell, George Franklin .....	Wichita	Henderson, Charles Franklin .....	Parsons
Gsell, Jacob Franklin .....	Wichita	Henderson, Edward Emmett .....	Columbus
Gulick, Arthur Cornelius .....	Goodland	Henneberger, Charles Ellsworth .....	Atwood
H			
Haage, Delbert Otto .....	Augusta	Hennenrich, Otto Andrew L. ....	Hays
Haas, Karl C. ....	Kansas City	Henning, Calvin Wilbur .....	Ottawa
Haas, Louis Richard .....	Pittsburg	Henning, Joseph Regnald .....	Ottawa
Haerle, Edward Jacob .....	Minneapolis	Henry, Schubert David .....	Kansas City, Mo.
Haerle, Henry .....	Marysville	Henshall, James Edgar .....	Osborne
Hagan, Condon Thomas .....	Wichita	Herrick, William Yetter .....	Wakeeney
Hagan, Francis James .....	Wichita	Hershner, Charles S. ....	Esbon
Hagan, Martin .....	Wichita	Hertzler, Arthur Emanuel .....	Halstead
Haggman, Charles Victor .....	Scandia	Hertzler, John William .....	Newton
Hagler, Carl William .....	Topeka	Heryford, Jacob R. ....	Hiawatha
Haigler, Frederick Herman .....	Pittsburg	Hesser, Herbert Harold .....	Kansas City
Haigler, James Pierre .....	Hays	Hewitt, John Everett .....	Wakefield
		Hibbard, James Sutherland .....	Wichita

Hibbard, Samuel M.	Sabetha	Jager, Thor Jager	Wichita
Hibbler, John Arthur, II	Kansas City, Mo.	James, Frank	Galena
Hiebert, Abraham Ezra	Wichita	Janney, James Garfield	Dodge City
Hiebert, Homer Leonard	Detroit, Mich.	Janzen, Herman Ferdinand	Hillsboro
Hiebert, Peter E.	Kansas City	Jarrott, John Bennett	Hutchinson
Higgins, Bruce Alvor	Sylvan Grove	Jeffries, Louis Albert	Jennings
Hilbig, Albert Lionel	Liberal	Jeffries, Robert Charles	Kansas City, Mo.
Hildyard, Victor Herbert	Baldwin	Jenney, Charles Maxwell	Salina
Hill, Edwin Ruthben	Lyons	Jenson, James Lloyd	Colby
Hill, James Edward	Wellington	Johnson, Charles Hans	Kinsley
Hill, James Noah	Pratt	Johnson, Charles Nelson	Wichita
Hill, Lee Verne	Kansas City	Johnson, Chase Benjamin	Lawrence
Hinden, Jacob	Strong City	Johnson, Edward Albert	Kansas City
Hinkle, Thomas Clark	Onaga	Johnson, Edward Hinman	Peabody
Hinshaw, Alfred Horton	Sunflower	Johnson, Everett Wallace	Wichita
Hinshaw, Charles Theron	Wichita	Johnson, Joseph Harold	El Dorado
Hinshaw, Llewellyn Magellan	Bennington	Johnson, Lester Elmer	Wichita
Hinton, Elmer Ernest	Boston, Mass.	Johnson, Lewis David	Chanute
Hobart, Wilson Keith	Topeka	Johnson, William Nelson	Columbus
Hobson, George Henry	Kansas City	Jones, Charles Warner	Olathe
Hodgson, Jarvis Edward	Downs	Jones, Clem Hood	Galena
Hodson, Hervey Roland	Wichita	Jones, Edwin Murray	Atchison
Hoffer, John G., Jr.	Fort Meade, Md.	Jones, Harold Houston	Winfield
Hogeboom, Henry Buckmaster	Topeka	Jones, Hiram Penfield	Lawrence
Holmes, John Allison	Lawrence	Jones, Robert Young	Hutchinson
Holt, Thomas Tallman	Wichita	Jones, Sam	Hutchinson
Holter, Harold Vincent	Kansas City	Jones, William Raymond	Canton
Holwerda, George William	Lindsborg	Jordan, Ralph Ensign	Osborne
Hood, Tarlton Ambrose	Garnett	Joslin, Leeman Charles	Harper
Hood, Thomas Robin	Winfield	Joss, Chester Earle	Topeka
Hoover, Charles Oliver	Quinter	Jury, Herbert William	Claflin
Hope, Hugh Allen	Hunter		K
Horejsi, Alfred James	Ellsworth	Kaiser, Max Elliott	Ottawa
Horn, Harry Wallace	Wichita	Kalbfleisch, Ernest Leopold	Newton
Hostetter, Philip Harvey	Baldwin	Kasha, Robert Leonard	Valley Center
House, Raymond George	Wichita	Kassebaum, Glen Edward	El Dorado
Hovorka, Joseph John	Emporia	Kassel, Henry William	Kansas City
Howard, Donald Osgood	Wichita	Keaney, Robert Emmett	Topeka
Howard, Robert Osgood	Wichita	Keller, Oris Guy	Franklin
Howell, J. Allen	Wellington	Kelly, John William	Louisburg
Huffman, Charles S.	Columbus	Kemphorne, Charles Roosevelt	Manhattan
Hughbanks, James Gard	Independence	Kendall, Donald Addison	Great Bend
Hughes, Raymond Hickman	Manhattan	Kennedy, Francis David	Norton
Hunicutt, Cecil Claude	Sabetha	Kennedy, John Thomas	Blue Mound
Hunter, John Davis	Fort Scott	Kenoyer, William Ray	Hugoton
Hunter, Kenneth Ross	Lebo	Kerley, Granvil Lessen	Topeka
Huntley, Leslie Loran	Washington	Kerr, Carey Caldwell	Council Grove
Hurst, Thomas Charles	Wichita	Kerr, Lambert A.	Lincoln
Hurtig, Henry George	Hanover	Ketner, Lester Ellsworth	Fort Scott
Husband, Myron Williams	San Francisco, Calif.	Kiehl, Otto B.	Pittsburg
Huscher, Gladys	West Africa	Kiene, Richard Hotchkiss	Kansas City, Mo.
Huston, Francis Wyatt	Winchester	Kierulff, George Browning	Melvern
Hutchinson, Robert Bruce	Lawrence	Kilbourn, Edward D.	Wichita
Hutchison, Owen Ghormley	Marysville	Kiltz, Richard Clyde	Everett, Wash.
Hyde, Marshall E.	Ottawa	Kimble, Thaddeus Carey	Miltonvale
Hymer, Edison Staton	Sedgewick	King, Emory Orville	Coulee Dam, Wash.
Hyndman, Henry Harold	Wichita	King, Harry Walter	Kansas City
		Kinnaman, Clarence Horace	Topeka
Inge, Claude William	Formoso	Kinnamon, Frank	Concordia
Irby, Addison Craft	Fort Scott	Kippenberger, Rinhart Ferdinand	Scott City
Irby, Pratt	Edmond, Okla.	Kirby, George Wightman	Wichita
Irby, William Jennings	Benton	Kirkpatrick, Hazen Leon	Topeka
Ireland, Edwin McCormick	Pratt	Kisecker, David Edgar	Caldwell
Isaac, Arnold Gerhard	Newton	Kiser, Willard Joyce	Wichita
Isaac, Elizabeth L.	Mound Ridge	Klein, Robert Gottfried	Dodge City
Isaacs, Fred Rife	Lawrence	Kleinheksel, John Lewis	Wichita
Isenberger, Robert Murray	Kansas City	Klingberg, William August	Hope
		Knapp, Leslie Eugene	Wichita
Jackman, Glenn Harold	Cimarron	Knappenberger, Roy C.	Penalosa

Knight, Durrell Keeling .....	Kansas City	Loyd, Dale Ulysses .....	Wichita
Knight, Robert Palmer .....	Topeka	Loyd, Earl Lavon .....	Rochester, Minn.
Knopp, James Arthur .....	Olathe	Loyd, Herlan Orville .....	St. Louis, Mo.
Koeneke, Irene Anita .....	Halstead	Loyd, Perry Armstrong .....	Salina
Koerber, Paul Ernst .....	Russell	Lozoff, Milton .....	Topeka
Koons, Franklin Walter .....	Halstead	Lucas, Robert Thomas .....	Kansas City
Kosar, Clarence Dewey .....	Concordia	Luke, John Henry .....	Kansas City
Krall, Paul Morton .....	Kansas City	Lutz, Harry .....	Augusta
Krehbiel, Bertrand Isaac .....	Topeka	Lyon, Charles Walter .....	Ellinwood
Kubin, Doris Aline .....	Kansas City	Lyons, Dave Joseph .....	Pittsburg
Kunce, F. Edward .....	Wichita	Lytle, Clinton Robert .....	McPherson
<b>L</b>			
Lafene, Benjamin William .....	Leonardville	McAllister, Robert Lewis .....	Marysville
Laing, Maurice Vincent .....	Kansas City	McCandless, Orville Calnon .....	Marion
Laing, Stanley Glen .....	Kansas City	McCarty, Claude E. ....	Dodge City
Landes, George Albert .....	Parsons	McClintock, Edward Arthur .....	Topeka
Lane, Henry Wallace .....	Lawrence	McClymonds, Robert Clendenin .....	Walton
Lanning, Robert Joseph .....	Junction City	McComas, Marmaduke D. ....	Courtland
Last, Harry .....	Leon	McComas, Marmaduke D., Jr. ....	Courtland
Latimer, Lester Arthur .....	Alexander	McComb, Fred Jackson .....	Wichita
Lattimore, John Lee .....	Topeka	McConchie, James Estil .....	Kansas City
Law, Lottie R. Findley .....	Hill City	McConnell, Archie Bernice .....	Burlington
Lawrence, Charles Waddle .....	Emporia	McCoy, Charles Patrick .....	Norman, Okla.
Lawrence, Edward King .....	Hiawatha	McCreight, Eugene James .....	Liberal
Lawson, Dwight .....	Topeka	McCreight, Marlin Samuel .....	Oskaloosa
Leavell, Frederick L. Bradford .....	Iola	McDermott, Alza Martin S. ....	Hollywood, Calif.
L'Ecuyer, Lynn Joseph .....	Greenleaf	McDonald, Ernest Cecil .....	Pittsburg
Lee, Carleton Harold .....	Wichita	McDonald, Orville Austin .....	Topeka
Lee, George Raymond .....	Yates Center	McDonnell, John Francis .....	Caldwell
Lee, James Grant .....	Bonner Springs	McDougal, Warren William .....	Colby
Lee, Robert Louis .....	Kansas City	McEwen, Fred John .....	Wichita
Leger, Lee Herman .....	Kansas City	McFarland, Morris Donald .....	Winchester, Mass.
Leigh, Lawrence Elliott .....	Overland Park	McGill, Lucien Robert .....	Great Bend
Leiker, Raymond Joseph .....	Great Bend	McGowan, Edwin Charles .....	Victoria
Lemon, Frederick Franklin .....	Douglas	McGrew, John Merritt .....	Wellington
Lenski, Frank, Jr. ....	Iola	McGuire, John W. ....	Nodesha
Leonard, Roosevelt .....	Lyons	McIlhenny, Robert Campbell .....	Co-wy Springs
Lerrigo, Charles Henry .....	Topeka	McIlvain, Guy Benton .....	Clay Center
Leverich, Leslie .....	Dallas, Tex.	McIntosh, Eben Seton .....	Burns
Lewis, George Kenneth .....	Chicago, Ill.	McKean, Willis Hirst .....	Kansas City
Lewis, James Tyree .....	Fort Scott	McKee, Dick Beguin .....	Pittsburg
Lewis, Letteer George H. ....	Kansas City, Mo.	McKee, Leo Francis .....	Cottonwood Falls
Liddy, Eugene Daniel, Jr. ....	Lawrence	McKee, Richard Stewart .....	Leavenworth
Lies, Barthel Nickolas .....	Colwich	McKeown, Charles Davis .....	Wichita
Light, Ralph Allison .....	Chanute	McKinben, Joe Tony .....	Cherokee
Lightfoot, Earl Claxton .....	Girard	McKinley, Walter Etna .....	Osawatomie
Lindquist, Paul Albert .....	Kansas City	McKinney, William .....	Baxter Springs
Lindsay, William Sharp .....	Topeka	McKnight, Ellis Buford .....	Alma
Lins, Beatrice Martha .....	Lawrence	McLaughlin, Chilton W. ....	Kansas City
Little, Lloyd Gilbert .....	Wichita	McLaughlin, James Arthur .....	Greensburg
Loewen, Henry Homer .....	Wichita	McManis, James Edwin .....	Havensville
Loewen, Peter Schellenberg .....	Wichita	McMillion, John Dibrell .....	Coffeyville
Lofgreen, Sylvia Young .....	Ottawa	McNair, Charles Francis .....	Hutchinson
Lofgreen, Victor Josiah .....	Ottawa	McNaughton, James Harvey .....	Topeka
Lohrentz, Abraham Martens .....	McPherson	McNickle, Jerry Hal .....	Ashland
Long, Carl Elijah .....	Norton	McReynolds, Albert Ray .....	Wichita
Longenecker, Charles Willard .....	Kingman	McVay, Roy Bruce .....	Clay Center
Longwood, Orlin William .....	Stafford	McWilliams, Cline Van Sandt .....	Kansas City
Loomis, Sydney P. ....	Herington	<b>M</b>	
Lorhan, Paul Herman .....	Kansas City	MacLeod, Sherburne .....	Wichita
Lose, Fred Davilla .....	Madison	Magee, Charles Raymond .....	Wichita
Love, William Albert .....	Kansas City	Magee, David Miller P. ....	Marianna, Fla.
Loveland, Forrest Leon .....	Topeka	Maggard, Delano Irvin .....	Wichita
Low, Joseph Heaton .....	Coffeyville	Major, Ralph Hermon .....	Kansas City, Mo.
Low, William Grant .....	Colorado Springs, Colo.	Maker, Louis Edward .....	Topeka
Lowe, Orrin C. ....	Paola	Mallory, Ben Franklin .....	Arlington
Lowery, Thomas Andrew .....	Wichita	Mandeville, George .....	Spearville
Lowman, Richard Clark .....	Kansas City	Manley, Joseph Warren .....	Kansas City
Loy, David Taylor .....	Great Bend	Manning, Harris W. ....	Emporia

Marchbanks, Howard E.	Pittsburg	Millis, Earl Romaine	Kansas City
Marcotte, Oscar Francois	Topeka	Mills, Charles Denton	Wichita
Marker, Daniel Isaac	Manhattan	Mills, Earl Lee	Hempstead, N. Y.
Markham, Homer Everett	Ottawa	Mills, Fred Edward	Kansas City
Markham, Howard C.	Parsons	Mills, Lewis Dell	Mound City
Markham, Robert Marion	Pittsburg	Mills, William Merrill	Topeka
Marr, James Tilden	Memphis, Tenn.	Miner, Elmer Andrew	Independence
Marrs, Edward Arlington	Sedan	Miner, Oliver William	Garden City
Marshall, Bromell Moeser	Topeka	Minnick, Charles Vernon	Junction City
Marshall, George Dinsmoor	Colby	Missildine, John Gurley	Wichita
Marshall, Hal Ellsworth	Wichita	Mitchell, John Charles	Salina
Marshall, Harley	Herington	Mollohan, Morgan Luther	Seneca
Martin, Albert Edward, Jr.	Coffeyville	Montee, Clarence Martin	Pittsburg
Martin, Earl Augustus	Parsons	Montgomery, Charles Ellsworth	Kansas City
Martin, Gertrude Elizabeth	Sterling	Montgomery-Short, Ruth Gertrude	Wichita
Martin, Gordon Mather	Kansas City	Montzingo, Edward Ravencroft	Attica
Martin, Guy Edward	Concordia	Moon, Rodger Allen	Emporia
Martin, John Neal	Kansas City	Moore, David John	Dexter
Martin, Melvin Cecil	Newton	Moore, James Milton	Spring Hill
Martin, Oliver Lilbourn	Salina	Moore, Robert Hollingworth	Lansing
Martin, Thaddeus Philip	Topeka	Moorhead, Frank Allen	Neodesha
Maser, George Roland	Overland Park	Moorman, Victor Reuben	Nickerson
Matassarin, Frederick William	Wichita	Moran, Charles Thomas	Arkansas City
Mathews, Hugh Howard	Topeka	Morgan, George William	Savonburg
Maxfield, Russell J.	Garden City	Morgan, Harold Eugene	Newton
Maxwell, Robert Hayden	Wichita	Morgan, Philip Wilhelm	Emporia
May, James Whittier	Kansas City, Mo.	Morley, Fred Henry	Roxana, Ill.
Mayer, Benjamin Harrison	Ellsworth	Morris, Benjamin Smith	Quinter
Mayes, William Fred	Topeka	Morris, Earl Fayette	Larned
Mays, Charles Oscar	Liberal	Morris, Harold Thoes	Topeka
Means, Robert Ross	Red Lodge, Mont.	Morrison, George Brooks	Wichita
Meckfessel, Frank G. H.	Lewis	Morrison, Hector	Smith Center
Medearis, Donald Norman	Kansas City	Morrison, Ira Robert	Atchison
Meek, George Chester	Arkansas City	Morrison, Scott D.	LaCygne
Meeker, Bruce Paul	Wichita	Morrow, Nelson Case	Parsons
Mehrle, Martin	Pittsburg	Morton, Warren Ralph	Green
Meidinger, Ray	Hiawatha	Moser, Ernest Clyde	Holton
Meisburger, Richard Gordon	Los Angeles, Calif.	Moser, Roy Hector	Holton
Melchert, Harold Bruce	Manhattan	Moses, Howard Nelson	Salina
Melencamp, Noble Elmo	Dodge City	Mothershead, John Lee	Denton
Mellott, Lennert Boyd	Kansas City, Mo.	Mott, James M., Jr.	Kansas City
Melton, Daniel Walter	Preston	Mott, James Mabbitt	Lawrence
Melton, Ralph Robert	Marion	Mullen, Clifford John	Kansas City
Menehan, Frank Lionel	Wichita	Muller, Samuel Barton	Pittsburg
Menninger, Charles Fredric	Topeka	Mundell, Minnette Smith	Hutchinson
Menninger, Karl Augustus	Topeka	Mundell, Walter Newton	Hutchinson
Menninger, William Claire	Topeka	Munger, C. Herbert	Emporia
Merideth, Clyde O., Jr.	Emporia	Murfitt, Malcolm Clement	Lindsborg
Merriam, Wallace	Rockaway Beach, Mo.	Murphy, C. Henry	Wichita
Metcalf, Ralph J.	El Dorado	Murphy, Lyman Clements	Wichita
Michener, Robert Bryan	Wichita	Myers, Robert William	Kansas City
Michener, William Ernest	Topeka	Myers, Samuel Monteith	Corning
Mielke, Charles Harry	Kansas City	N	
Milbank, George Edward	Wichita	Nanninga, John Benjamin	Newton
Miles, Paul Wendell	Newton	Naramore, James Thomas	Larned
Millard, Samuel Thomas	Topeka	Nash, Arthur Richard	Parsons
Miller, Bert Elby	Council Grove	Nash, Francis James	Kansas City
Miller, Charles Henry	Parsons	Nash, Newman Curtis	Wichita
Miller, Charles Melbourne	Oakley	Nason, Zacharias Miles	Kansas City
Miller, Clyde Wortham	Wichita	Naylor, Noble Elroy	Wellsville
Miller, Eldon Stiles	Kansas City	Neas, Ingall Howard	Muncie
Miller, Henry Blackburn	Rossville	Need, Omar Ulysses	Oak Hill
Miller, Herbert Chauncey	Kansas City	Neel, William Herschel	Wellington
Miller, Milton Bradford	Topeka	Neighbor, Ernest Garland	Kansas City
Miller, Mohler Jacob	Kansas City, Mo.	Neighbor, Gaylord Pritchard	Kansas City
Miller, Philip Garrett	Anthony	Nelson, Barrett Arthur	Manhattan
Miller, Riley Hess	Ulysses	Nelson, Carl Ferdinand	Lawrence
Miller, Walter W.	Osborne	Nelson, Chester Martin	Oberlin
Millington, Guy Leroy	Girard	Nelson, Laurence Strong	Salina

Nelson, Lois Margaret .....	Lawrence	Peck, James Haddon A. ....	St. Francis
Nelson, Richard Oldfield .....	Lawrence	Peckenschneider, Lloyd Orval E. ....	Halstead
Nelson, William Oliver .....	Lawrence	Peete, Don Carlos .....	Kansas City, Mo.
Neptune, Harold Everett .....	Salina	Pendleton, Raymond Lancing .....	Lawrence
Neptune, John Wesley .....	Salina	Pennington, Katherine .....	Wichita
Nesselrode, Clifford Calvin .....	Kansas City	Perry, Middleton Lee .....	Topeka
Nevitt, James Russell .....	Iola	Peters, Glenn R. ....	Kansas City
Nevitt, Rollin Roy .....	Moran	Petersen, Daniel .....	Herington
Newman, Carl Sullivan .....	Pittsburg	Peterson, Emmet Eugene .....	Halstead
Newman, Charles Marshall .....	Axtell	Petitt, Percy A. ....	Paola
Newman, Clifford Blenn .....	Pittsburg	Petterson, Cecil Edward .....	Norton
Newman, John Ross .....	Fort Scott	Petterson, Edward Chester .....	Plainville
Newman, Malcolm C. ....	Topeka	Petterson, O'Ruth Sisk .....	Ellsworth
Newman, Robert Lewis .....	Kansas City	Pettet, Joseph David .....	Pittsburg
Newton, William Brown .....	Glasco	Pettijohn, Walter Johnston .....	Russell
Nichols, Roscoe Townley .....	Hiawatha	Pettis, Arthur Leroy .....	El Dorado
Nichols, Schuyler .....	Herington	Petty, Charles Napoleon .....	Altamont
Nicoll, David Thomson .....	Topeka	Pfuetze, Robert Emil .....	Topeka
Nienstedt, John F. ....	Beloit	Phillips, Benjamin Lane .....	Paola
Nipple, Frederic E. ....	Mulberry	Phillips, Frederick Nathaniel .....	Kansas City
Nix, Lester Killough .....	Wichita	Phillipsen, John Albert .....	Wellington
Nodurft, Elmer J. ....	Wichita	Pickett, William H. ....	Kansas City
Norman, William Grant .....	Cherryvale	Pile, Eugene .....	Wichita
Norris, George Loren .....	Winfield	Pinsker, Jacob A. ....	Hutchinson
Norris, Robert P. ....	Seattle, Wash.	Piper, Dorus H. ....	Osawatomie
Northrup, John Fredrick .....	Topeka	Pitman, Will D. ....	Pratt
Nothnagel, Arnold Fred .....	Kansas City	Plett, John Victor .....	Kansas City
Nutting, Harry Clifford .....	Emporia	Plowman, Carl Wesley .....	Jewell

**O**

O'Connell, Paul James .....	Kansas City, Mo.
O'Connor, Thomas Augustine .....	Topeka
O'Donnell, Alfred .....	Ellsworth
O'Donnell, Arthur Edwin .....	Junction City
O'Donnell, Frederick William .....	Junction City
O'Donnell, Harold Frederick .....	Wichita
O'Donnell, Henry St. Clair .....	Ellsworth
O'Donnell, Leonard Aloysius .....	Wichita
O'Donnell, Richard H. ....	Ellsworth
Olson, Andrew Allen .....	Wichita
Oltman, Theodore Voorhorst .....	Newton
Orr, Thomas Grover .....	Kansas City
Ott, Leroy S. S. ....	Leoti
Overholser, Norman H. ....	El Dorado
Owen, Arthur Kirk .....	Topeka
Owen, Elijah Mobry .....	Lawrence

**P**

Pace, John David .....	Parsons
Padfield, Earl George .....	Salina
Padfield, Robert Elmer .....	Wichita
Paine, George Edward .....	Hutchinson
Palmer, Dale Horace, Jr. ....	Wichita
Palmer, Harold William .....	Wichita
Palmer, Henry Preston .....	Scott City
Palmer, William Robert .....	Lawrence
Palmer, William Rolland .....	Kansas City
Parker, Bernard Barney .....	Topeka
Parker, Clarence Avery .....	Wichita
Parker, David Findley .....	Tonganoxie
Parker, Dean Brownfield .....	Ness City
Parker, Victor Robert .....	Natoma
Parmley, Charles Clifford .....	Wichita
Parrish, William Allen .....	Pittsburg
Partridge, Clyde Elmer .....	Emporia
Patterson, Harold Loyd .....	Bushton
Patton, Chester Leroy .....	Emporia
Patton, George Andrew .....	Atchison
Pauley, Vern Lawrence .....	Wichita
Pearson, Walter J. ....	Kansas City

**Q**

Quantius, Rachel Houston .....	McPherson
Quiring, Walter Otto .....	Hutchinson

**R**

Rabe, Melvin Alvis .....	Leavenworth
Raines, Omer Marvin .....	Topeka
Rainey, Edward Carlyle .....	Wichita
Rainey, Norris Luetscher .....	Wichita
Ralls, Clayton Thomas .....	Winfield
Ramsey, Carey Louis .....	Topeka
Randell, John Wesley .....	Marysville
Randles, Herbert .....	Fort Scott
Randles, Leland Price .....	Fort Scott
Ratzlaff, Abraham Karl .....	Goessel
Rautert, Julius Henry .....	Kansas City
Raynolds, Elmer L. ....	Mankato
Reece, Adelbert Samuel .....	Gardner
Reed, William Wallace .....	Topeka
Reeves, Eugene Albert .....	Kansas City
Regier, Henry Lewis .....	Kansas City
Regier, Wilhelm Edward .....	Whitewater
Reichley, Elmer Jacob .....	Herington
Reid, James D. ....	Wellsville

Reid, Turner W.	Gardner	Topeka
Reifsneider, Joseph Stanley	Wichita	Burrton
Reinhardt, John Herman	Glen Elder	Burlingame
Reinhardt, Robert August	Glen Elder	Burlingame
Reitz, Harvey Edward	Wichita	Wichita
Reitzel, Walter Maywood	Manhattan	Iola
Relihan, Francis Henry	Smith Center	Lyons
Renick, Fred Taylor	San Antonio, Tex.	Newton
Renner, Marion John	Goodland	Manhattan
Rettenmaier, Albert Joseph	Kansas City	Hutchinson
Revell, Arthur Joseph	Wichita	Kinsley
Revell, Arthur T.	Columbus	Hutchinson
Reynolds, Lloyd Walter	Hays	Girard
Rhoades, Gordon Howard	Halstead	Kansas City
Rich, Oliver Smith	Wichita	Blue Rapids
Rich, William Tilton	Neodesha	Manhattan
Richards, George William	Kansas City	Lawrence
Richeson, Rae Arthur	Kansas City	Moline
Richmond, F. E.	Stockton	Wichita
Richmond, Louise Finlaw	Hutchinson	Topeka
Riedel, Robert Henry	Topeka	Wichita
Rieke, Frank Arthur	Kansas City	Salina
Riley, Fred Patrick	St. Marys	Kansas City
Riley, Ray Burney	Kansas City	Walnut
Rinehart, William Galeard	Pittsburg	Wichita
Risdon, James Waldo	Leavenworth	Kansas City
Rivard, Raymond Robert	Wisconsin	Independence
Roach, Harry Marshall	Lawrence	Clay Center
Robb, Robert Worth	Independence, Iowa	Larned
Robbins, Agnes Louise	Kansas City	Neodesha
Robbins, Lewis Lelewel	Topeka	Wichita
Roberts, Howard Emerson	Topeka	Elmdale
Roberts, Louis Sidney	Wichita	Coldwater
Robertson, Edwin Norris, Sr.	Concordia	Simpson
Robertson, Howard Thomas	Denver, Colo.	Pittsburg
Robinson, Leo David	Iola	Neodesha
Robison, Corbin Ellis	Hoisington	Neodesha
Robison, Norval William	Bison	Salina
Roe, Mary Elizabeth	Norton	Elmdale
Rollow, Royal Herbert	Chanute	Elmdale
Romold, Charles Roy	Wichita	Chanute
Rook, Lee Emerson	Kansas City	Norway
Rose, Ralph James	Parsons	Kansas City, Mo.
Ross, Earl B.	Wichita	Lawrence
Rossetto, Anthony Francis	Wichita	Emporia
Roth, Nathan	New York, N. Y.	Holton
Rottluff, Karl Moritz	Bonner Springs	Pleasanton
Rubbra, Jean Olive	Kansas City	Wichita
Ruble, Mirl Calvin	Parsons	Topeka
Rucker, Clemens	Sabetha	Newton
Rucker, Martin Joseph	Sabetha	Topeka
Rueb, Andrew Edwin	Salina	Wichita
Rumold, Mervin James	Kansas City, Mo.	Wichita
Rupp, Jacob Roth	Russell	Lyndon
Rush, Floyd Harold	Pittsburg	Leavenworth
Russell, Guy Jewell	Kansas City	Junction City
Russell, Marion Fore	Great Bend	Junction City
Ruzicka, Lawrence Joe	Belleville	Winfield
Ryan, Maurice James	Kansas City	Sedan
Ryan, Michael Joseph	Kansas City	Pittsburg
S		
St. John, Hugh Roberts	Concordia	Rossville
Sandidge, Allen Wilson	Mulberry	Wichita
Sandidge, James Gilmer	Mulberry	Lyndon
Sartorius, Herman Carl	Garden City	Leavenworth
Saxe, Earl	New York, N. Y.	Atlanta
Saylor, Leslie Lavelle	Chicago, Ill.	Topeka
Scales, William McVey	Hutchinson	St. Marys
Schaefer, Leo Joseph	Salina	Marion

Smith, Roy Kenneth .....	Norton	Sullivan, Henry Bradley .....	Shawnee
Smith, Thomas Elmo .....	Independence	Summerville, Ward White .....	Kansas City
Smith, Thomas Harold .....	Seagoville, Tex.	Surface, Gardner Allaire .....	Ellis
Smithheisler, James Rolland .....	Richmond	Sutter, Loe Albright .....	Wichita
Snook, Robert Rufus .....	Manhattan	Sutton, Edgar Milton .....	Salina
Snyder, Cecil Dawson .....	Winfield	Suwalsky, Adelbert L. ....	Leavenworth
Snyder, Henry Galen .....	Seneca	Swails, John Goldsborough .....	Watheana
Snyder, Howard Errol .....	Winfield	Swaney, Hugh Martin .....	Goodland
Snyder, Maurice .....	Salina	Swann, Leo John .....	Leavenworth
Snyder, Z. Hosea .....	Greenleaf	Swanson, John Theodore .....	Independence
Soanes, Jabez George .....	Kansas City	Swart, William Sheridan .....	Girard
Sohlberg, Robert, Jr. ....	McPherson		T
Songer, Herbert Lee .....	Lincoln	Taggart, Floyd Cornelius .....	Topeka
Spake, LaVerne B. ....	Kansas City	Tallman, Ernest Walter .....	Gaylord
Spann, Frederick Nimrod .....	Topeka	Tapscott, John Hadley .....	Rozel
Spearing, Joe Hall .....	Columbus	Tate, Wendell Maurice .....	Peabody
Spearing, Joseph Watkins .....	Columbus	Taylor, Charles Fletcher .....	Norton
Speer, Frederic Aiken .....	Kansas City	Terrill, Edwin Harold .....	Wichita
Speer, Leland N. ....	Kansas City	Terry, Jack Trebling .....	Hardtner
Speer, Louis Newton .....	Ottawa	Thacher, George Isaac .....	Waterville
Speer, Newton C. ....	Kansas City	Thacher, Mowry Safford .....	Turon
Speer, William Louis .....	Osawatomie	Theis, Peter Frank .....	Arkansas City
Speirs, Richard Everett .....	Dodge City	Thierstein, Samuel Theodore .....	Whitewater
Spencer, Harold Ferdinand .....	Emporia	Thomas, Charles Alfred .....	Wichita
Splichal, William Francis .....	Belleville	Thomas, Henry David .....	Belleville
Spray, George Albert .....	Wichita	Thomas, Leon B. ....	Russell
Springer, Ralph W. ....	Harper	Thompson, Burl Vedder .....	Wellington
Sprong, Aaron Alfred .....	Sterling	Thompson, John Ernest .....	Huron
Squire, Edwin Ora .....	Coffeyville	Thompson, Solomon Henry .....	Kansas City
Stacey, Harley James .....	Leavenworth	Thorpe, Francis Adams .....	Pratt
Stahl, Clare William .....	Topeka	Thorpe, George Lawrence .....	Wichita
Stahlman, David C. ....	Potwin	Tice, Galen Martin .....	Kansas City
Starr, Charles Mike .....	Hollywood, Calif.	Tice, Raymond S. ....	Akron, Ohio
Starr, R. P. Ellis .....	Denver, Colo.	Tihen, Henry Nelson .....	Wichita
Steadman, Leonard Somerville .....	Junction City	Tiller, Dean Jack .....	Wichita
Steegman, Albert Theodore .....	Mission	Tillman, Carl Gustaf D. ....	San Francisco, Calif.
Steelsmith, Simon Peter M. ....	Abilene	Tippin, Ernest Elwood .....	Wichita
Steffen, Lawrence Francis .....	El Dorado	Titus, Albert Ernest .....	Cottonwood Falls
Steffen, Marvin Omar .....	Great Bend	Tomlinson, Louis Monroe .....	Harveyville
Steichen, Edward Francis .....	Lenora	Tonn, Gerhart Rudolph .....	Wichita
Steinhauser, William Michael .....	Hiawatha	Torrance, Fred Emerson .....	Winfield
Steinzeig, Alfred Sidney .....	Kansas City	Townsend, Charles Rees .....	Centralia
Stelle, Harry Lewis .....	Pittsburg	Townsend, Pinkney Shannon .....	Coffeyville
Stensaas, Carl Oscar .....	Arkansas City	Trees, Clyde Beverly .....	Topeka
Stephens, Charles Benedict .....	Topeka	Trees, Donald Paul .....	Wichita
Stephenson, Lucille Carman .....	St. Francis	Tretbar, Friedrich Wilhelm .....	Stafford
Stephenson, Walter .....	Norton	Tretbar, John Julius .....	Stafford
Sterett, David Robb .....	Leavenworth	Trimble, David Paul .....	Emporia
Sterrett, William Preston .....	Collins, Mo.	True, Otis Haviland .....	Hays
Stevens, Delos Meeker .....	Oskaloosa	Trump, Frank Austin .....	Ottawa
Stevenson, Charles E. ....	Neodesha	Tucker, Claude C. ....	Wichita
Stevenson, Onnie Earle .....	Parsons	Turgeon, Leo Victor .....	Topeka
Stewart, Henry Milton .....	Hutchinson	Turner, Herschel Roy .....	Hope
Stewart, James Graves .....	Topeka	Turner, John Washington .....	Bloomington, Ill.
Stewart, Richard A. ....	Hutchinson	Tyler, Mary Whelan .....	Chicago, Ill.
Stewart, William John .....	Frankfort		U
Stock, Karl William .....	Topeka	Ubelaker, Ernest John .....	South Haven
Stocks, Pauline Violet .....	Bushong	Ulrey, John Calvin .....	St. John
Stoll, John Boer .....	Clay Center	Underwood, Charles Clinton .....	Emporia
Stone, Francis M., Jr. ....	Kincaid	Underwood, Harry Anson .....	Kansas City
Stone, Gordon Earl .....	Hutchinson	Ungles, James Bonner .....	Satanta
Stone, William French, Jr. ....	Tulsa, Okla.	Unrein, Gerard Cassian .....	Hays
Stotts, Charles Stephen .....	Fredonia	Unruh, Rudolph Theodore .....	Kinsley
Stout, Samuel Lloyd .....	Wichita	Updegraff, Alpha Daniel .....	Wichita
Street, Glenn Q., Jr. ....	Wichita	Updegraff, Chester Deric .....	Greensburg
Strode, Lindley Edgar .....	Girard	Urie, Rolland William .....	Parsons
Strohm, Ralph Yoder .....	Fort Scott		V
Stuart, Francis Ignatius .....	Atchison		
Sudler, Mervin Tubman .....	Lawrence	Valette, Horace Bernard .....	Beloit

Van Cleve, Joseph Vincent .....	Wichita	Wheeler, James Albert .....	Newton
VanDeventer, Roy William .....	Wellington	Wheeler, LeRoy J. ....	Great Bend
Van Noy, Harvey Elijah .....	Lawrence	Whitaker, Arthur .....	Atchison
Van Pelt, Clifford Alexander, Jr. ....	Junction City	White, Charles L. ....	Great Bend
Van Pelt, Clifford Levi .....	Paola	White, Fagan Nichols .....	Russell
VanScocoy, William Melvon .....	Fort Morgan, Colo.	White, Ralph Ersel .....	Garnett
Van Voorhis, Van Curtis .....	Robinson	White, Thaddeus Hug .....	Manhattan
Vaughn, Clarence Keane .....	Leavenworth	Whitley, Grover Grady .....	Douglass
Veatch, Harry John .....	Pittsburg	Wiedenmann, Eugene Maximilian .....	Topeka
Vermillion, Dale DeWitt .....	Goodland	Wier, Charles Kirkland .....	Wichita
Vermillion, Earl Leroy .....	Salina	Wiksten, Vernon Cornelius .....	Topeka
Vermillion, John Selby .....	Maize	Wilcox, John Constantine .....	Mulvane
Vesper, Vernon Alfred .....	Hill City	Wilcox, Carl John W. ....	Manhattan
Vest, Frederick Eugene .....	Topeka	Wilkening, William Theodore .....	Fort Scott
Vestle, Charles Edmonde .....	Humboldt	Williams, Charles LaFayette .....	Independence
Vinsant, Vester Ray .....	Summerfield	Williams, Ernest Dyer .....	Kansas City
Voldeng, Karl Edward .....	Wellington	Williams, Harold Otis .....	Cheney
von Trebra, Ernestine Louise .....	Chetopa	Williams, Homer John .....	Osage City
von Trebra, Robert L. ....	Chetopa	Williams, Lester Leo .....	El Dorado
Voorhees, Gordon Stanley .....	Leavenworth	Wilmer, Francis M. ....	Winfield
W			
Wagar, Leonard Sweete .....	Florence	Wilmoth, William Law .....	Blue Rapids
Wahl, Harry Roswell .....	Kansas City	Wilson, Clyde .....	Emporia
Wakeman, Don Conklin .....	Topeka	Wilson, Donald James .....	Fort Sam Houston, Texas
Walker, Charles William .....	Eskridge	Wilson, Donald Ray .....	Mound Valley
Walker, George Alvin .....	Kansas City	Wilson, Lawrence Smith .....	McCune
Walker, Guy R. ....	Hutchinson	Wilson, Lewis Barrick .....	Kansas City
Walker, Maurice Andrew .....	Kansas City	Wilson, Robert Benjamin .....	New Orleans, La.
Walker, Nellie Gross .....	Racine, Wis.	Wilson, Sloan J. ....	Kansas City
Walker, Oliver D. ....	Salina	Wilson, W. Errol .....	Monte Vista, Colo.
Walker, William Herbert .....	Robards, Ky.	Winkle, Vernon Melvin .....	Topeka
Walker, William James .....	Topeka	Wittmann, Albert Frank .....	Wichita
Wall, Victor Juble .....	Mahaska	Wolfe, James Edwin .....	Wichita
Wallace, Floyd Eldridge .....	Chase	Wolff, Frederick P. ....	Kansas City
Wallace, Wayne Orrin .....	Atchison	Wolhon, Harry Cofman .....	Mineral
Wallen, James Elisha .....	Ottawa	Wood, Douglas Hodges .....	Pittsburg
Waller, Charles Edward .....	Troy	Wood, Orlin Pearl .....	Marysville
Walsh, William Stanley .....	Halstead	Woodard, Parke Harold .....	Lawrence
Walters, Byron Wesley .....	Marquette	Wooden, George Maurice .....	Argonia
Walters, Orville Selkirk .....	McPherson	Woodhouse, Charles Leonard .....	Wichita
Walz, Thomas Julius .....	St. Francis	Woodhull, Maurice Welch .....	Parsons
Ward, Delbert Audray .....	Arkansas City	Woods, Harold Harrison .....	Topeka
Warfield, Chester H. ....	Ft. Wayne, Ind.	Woods, Samuel Delos E. ....	Osawatomie
Warren, Wirt Adrien .....	Wichita	Woods, Walton Clay .....	San Francisco, Calif.
Warriner, William Lucian .....	Topeka	Wooster, Winifred Viers .....	Minneapolis
Warts, Victor Everitt .....	Smith Center	Worthington, Robert Langhorne .....	Topeka
Waxse, Isadore Joseph .....	Oswego	Wright, Lennel Irwood .....	Wichita
Waylan, Thornton Lewis .....	Nashville	Wrightman, Frederick Efner .....	Sabetha
Weaver, James Branson .....	Kansas City	Wulff, Edwin Theodore .....	Atchison
Weaver, Ross Eberhardt .....	Concordia	Wyatt, Charles Arthur .....	Holton
Weaver, Theodore Walker .....	Wichita	Y	
Webb, Herbert Melville .....	Humboldt	Yasuda, Hiroshi .....	Hardtner
Weber, Clarence Jacob .....	Kansas City	Yates, Charles E. ....	Baldwin
Webster, Paul Reichard .....	Leavenworth	Young, Chester Lee .....	Kansas City
Weigel, Bernard John .....	Gorham	Young, Claud Franklin .....	Fort Scott
Wells, Alvin Y. ....	Winfield	Young, Pearl Raymond .....	Ottawa
Wells, Max Welton .....	Le Roy	Young, Richard Claude .....	Arkansas City
Weltmer, Wardie Wallace .....	Beloit	Young, Robert Swisher .....	Fort Scott
Wenke, Leo Louis .....	Portland, Ore.	Youngman, Charles L. ....	Harveyville
Wentworth, Jesse LeRoy .....	Arkansas City	Z	
Wenzel, Anna Marie .....	Hays	Zagaria, James Francis .....	Topeka
West, Charles Omer .....	Kansas City	Zimmer, Louis Kurt .....	Lawrence
West, Harry Andrew .....	Yates Center	Zimmerman, Leon Ward .....	Liberal
West, Henry Walker .....	Yates Center	Zugg, Clarence Logan .....	Arkansas City
West, Ray Augustine .....	Wichita	Zugg, Clark William .....	Great Bend
Westfall, George Arthur .....	Halstead		
Westfall, George Arthur, Jr. ....	Topeka		
Weston, William Graham .....	Arkansas City		
Wheeler, Howard M. ....	Kansas City		

## LISTED BY CITIES

<b>Abilene</b>	Condon, Albert Paul Deeths, Harry J. Fast, William Spencer Jones, Edwin Murray Morrison, Ira Robert Patton, George Andrew Stuart, Francis Ignatius Wallace, Wayne Orrin Whitaker, Arthur Wulff, Edwin Theodore	<b>Benton</b> Irby, William Jennings <b>Bison</b> Robison, Norval William	<b>Chanute</b> Ashley, George Lee Roy Ashley, Samuel Glick Butin, James Abram Cone, Luther Hose Garton, Avery Mortimer Johnson, Lewis David Light, Ralph Allison Rollow, Royal Herbert Sherman, John Norval
<b>Alexander</b>	Latimer, Lester Arthur	<b>Blue Mound</b> Kennedy, John Thomas	
<b>Allen</b>	Edwards, Elva Elton	<b>Blue Rapids</b> Schumann, Enoch Wilmoth, William Law	
<b>Alma</b>	McKnight, Ellis Buford	<b>Bonner Springs</b> Lee, James Grant Rottluff, Karl Moritz	
<b>Almena</b>	Bennie, Herbert Stewart	<b>Bucklin</b> Bandy, Claudius Estyl	
<b>Altamont</b>	Petty, Charles Napoleon	<b>Burden</b> Brooks, Edgar Ernest	
<b>Alton</b>	Goshorn, Herbert Renner	<b>Burlingame</b> Schenck, Franklin Ellis Schenck, Fred Gerald	
<b>Americus</b>	Beam, Albert	<b>Burlington</b> Gray, Albert Newton McConnell, Archie Bernice	
<b>Anthony</b>	Anthony	<b>Burns</b> McIntosh, Eben Seton	
	Galloway, Horace Lee Haughey, Charles Francis Miller, Philip Garrett	<b>Burr Oak</b> Poppen, Joseph A.	
<b>Arcadia</b>	Adamson, Adam Hancock	<b>Burton</b> Schaumloffel, Herman Gottfried	
<b>Argonia</b>	Wooden, George Maurice	<b>Bushong</b> Stocks, Pauline Violet	
<b>Arkansas City</b>	Arkansas City	<b>Bushton</b> Patterson, Harold Loyd	
	Clayton, Emanuel Harry Clayton, Ione Shultz Ferguson, Robert Leslie Hellweg, Edward Walter Meek, George Chester Moran, Charles Thomas Stensaas, Carl Oscar Theis, Peter Frank Ward, Delbert Audray Wentworth, Jesse LeRoy Weston, William Graham Young, Richard Claude Zugg, Clarence Logan	<b>Caldwell</b> Burnett, James Robinet Kisecker, David Edgar McDonnell, John Francis	
<b>Arlington</b>	Mallory, Ben Franklin	<b>Cambridge</b> Green, Will James	
<b>Ashland</b>	Burket, Ivan Roy McNickle, Jerry Hal	<b>Caney</b> Coon, William Franklin	
<b>Atchison</b>	Anderson, Winstan L. Bosse, Frank Krenning Brady, Charles Stuart Bribach, Eugene John	<b>Canon</b> Jones, William Raymond	
		<b>Cedar Vale</b> Edwards, Estella Mae Hays, Leslie Claire	
		<b>Centralia</b> Hayley, Bernice Gorsuch Townsend, Charles Rees	
		<b>Bennington</b> Hinshaw, Llewellyn Magellan	

Grigsby, Clement E.  
 Low, Joseph Heaton  
 McMillion, John Dibrell  
 Martin, Albert Edward, Jr.  
 Squire, Edwin Ora  
 Townsend, Pinkney Shannon

**Colby**

Eddy, Victor Cooper  
 Jenson, James Lloyd  
 McDougal, Warren William  
 Marshall, George Dinsmoor

**Coldwater**

Shelley, Robert Alexander J.

**Columbus**

Athy, Gregg Barr  
 Bux, Donald Eugene  
 Fuller, Clinton Charles  
 Henderson, Edward Emmett  
 Huffman, Charles S.  
 Johnson, William Nelson  
 Revell, Arthur T.  
 Spearing, Joe Hall  
 Spearing, Joseph Watkins

**Colwich**

Lies, Barthel Nickolas

**Concordia**

Anderson, Cornelius Oscar  
 Filkin, Lawrence Elwood  
 Gelvin, Emmanuel Raymond  
 Haughey, Leo Eugene  
 Kinnamon, Frank  
 Kosar, Clarence Dewey  
 Martin, Guy Edward  
 Porter, John McGill  
 Robertson, Edwin Norris, Sr.  
 St. John, Hugh Roberts  
 Weaver, Ross Eberhardt

**Conway Springs**

Evans, Ellis Austin  
 McIlhenny, Robert Campbell

**Corning**

Myers, Samuel Monteith

**Cottonwood Falls**

McKee, Leo Francis  
 Titus, Albert Ernest

**Council Grove**

Aldis, John  
 Kerr, Carey Caldwell  
 Miller, Bert Elby

**Courtland**

McComas, Marmaduke D.  
 McComas, Marmaduke D., Jr.

**Cunningham**

Burnett, Ferd

**Delia**

Frisbey, William Redmon

**Delphos**

Ballard, Marshall Paul

**Denton**

Mothershead, John Lee

**Dexter**

Moore, David John

**Dodge City**

Alderson, Clair Milton  
 Alexander, Xeno Frederic  
 Busch, Anthony Bering  
 Davis, Donald Ray  
 Dowler, Vernon Booth  
 Gribble, Robert C.  
 Janney, James Garfield  
 Klein, Robert Gottfried  
 McCarty, Claude E.  
 Melencamp, Noble Elmo  
 Speirs, Richard Everett

**Douglass**

Lemon, Frederick Franklin  
 Whitley, Grover Grady

**Downs**

Hartig, Otto Joseph  
 Hodgson, Jarvis Edward

**Dwight**

Brethour, George Edwin

**El Dorado**

Beckner, Ernest Jones  
 Boudreau, Clarence Edwin  
 Brian, Robert Milling  
 Cloyes, Arthur Pearson  
 Dillenbeck, Floyd Earl  
 Earp, Ralph Bowman  
 Johnson, Joseph Harold  
 Kassebaum, Glen Edward  
 Metcalf, Ralph J.  
 Overholser, Norman H.  
 Pettis, Arthur Leroy  
 Steffen, Lawrence Francis  
 Williams, Lester Leo

**Elkhart**

Buckmaster, Francis Henry

**Ellinwood**

Carlson, Marlin Winthrop  
 Gaume, James Garnet  
 Lyon, Charles Walter

**Ellis**

Surface, Gardner Allaire

**Ellsworth**

Horejsi, Alfred James  
 Mayer, Benjamin Harrison  
 O'Donnell, Alfred  
 O'Donnell, Henry St. Clair  
 O'Donnell, Richard H.  
 Petterson, O'Ruth Sisk

**Elmdale**

Shelley, Jacob Foster

**Emporia**

Butcher, Thomas Peck  
 Capps, Murl T.

Corbett, Arthur William

Corbett, Oliver John

Davis, David Richard

Eckdall, Frank Albert

Eckdall, Funston J.

Foncannon, Frank

Foncannon, Franklin William

Granger, Wayne Bernard

Hovorka, Joseph John

Lawrence, Charles Waddle

Manning, Harris W.

Merideth, Clyde O., Jr.

Moon, Rodger Allen

Morgan, Philip Wilhelm

Munger, C. Herbert

Nutting, Harry Clifford

Partridge, Clyde Elmer

Pattton, Chester Leroy

Shonkwiler, Francis Marion

Spencer, Harold Ferdinand

Trimble, David Paul

Underwood, Charles Clinton

Wilson, Clyde

**Erie**

Bryan, Emery Clarence

**Esbon**

Hershner, Charles S.

**Eskridge**

Walker, Charles William

**Eudora**

Blackburn, Lewis Claude

**Eureka**

Baird, Cecil Dryden  
 Basham, Francis Claybourne  
 Basham, James Joseph  
 Basham, John Henry  
 Grove, William Thomas

**Florence**

Wagar, Leonard Sweete

**Ford**

Coffman, Francis Marion

**Formoso**

Inge, Claude William

**Fort Scott**

Cooper, Lawrence Leon

Gench, Raymond Lane

Gooch, William S.

Hunter, John Davis

Irby, Addison Craft

Ketner, Lester Ellsworth

Lewis, James Tyree

Newman, John Ross

Prichard, Jesse Rees

Randles, Herbert

Randles, Leland Price

Strohm, Ralph Yoder

Wilkening, William Theodore

Young, Claud Franklin

Young, Robert Swisher

**Frankfort**

Bolton, Dan W.

Brawley, Mark Abernathy

Stewart, William John

**Franklin**

Keller, Oris Guy

**Frederia**

Beal, Lynn Elwood

Beal, Raymond Jameson

Duncan, Edgar Cecil

Flack, Alexander C.

Hayden, Abigail

Stotts, Charles Stephen

**Frontenac**

Gish, George J. P.

**Galena**

Browne, Herbert Andrew

James, Frank

Jones, Clem Hood

**Garden City**

Armantrout, Leonard Otho

Bailey, Sanford

Beiderwell, Earl Reade

Hastings, Grant Ray

Maxfield, Russell J.

Miner, Oliver William

Sartorius, Herman Carl

**Garden Plain**

Biermann, Aloysius Henry

**Gardner**

Reece, Adelbert Samuel

Reid, Turner W.

**Garland**

Albright, Fred Clayton

**Garnett**

Carter, John Nicholas

Hood, Tarlton Ambrose

White, Ralph Ersel

**Gaylord**

Tallman, Ernest Walter

**Girard**

Lightfoot, Earl Claxton

Millington, Guy Leroy

Schulte, Edward John

Strode, Lindley Edgar

Swart, William Sheridan

**Glasco**

Newton, William Brown

**Glen Elder**

Reinhardt, John Herman

Reinhardt, Robert August

**Goessel**

Ratzlaff, Abraham Karl

**Goodland**

Gulick, Arthur Cornelius

Renner, Marion John	Blake, Clyde Dale, Jr.	Hugoton	Lenski, Frank, Jr.
Swaney, Hugh Martin	Brewer, William McKelvey	Gammell, Denman Thompson	Nevitt, James Russell
Vermillion, Dale DeWitt	Bryan, Harry Raymond	Kenoyer, William Ray	Robinson, Leo David
	Coffey, Frank Ellsworth		Schmaus, Lyle Francis
<b>Gorham</b>	Eddy, Murray Chadwick	<b>Humboldt</b>	
Weigel, Bernard John	Haigler, James Pierre	Vestle, Charles Edmonde	<b>Jennings</b>
	Hennerich, Otto Andrew L.	Webb, Herbert Melville	Hardesty, Henry Osmond
<b>Great Bend</b>	Reynolds, Lloyd Walter		Jeffries, Louis Albert
Embry, Horace Crandell	True, Otis Haviland	<b>Hunter</b>	
Kendall, Donald Addison	Unrein, Gerard Cassian	Hope, Hugh Allen	<b>Jewell</b>
Leiker, Raymond Joseph	Wenzel, Anna Marie		Plowman, Carl Wesley
Loy, David Taylor		<b>Huron</b>	
McGill, Lucien Robert		Thompson, John Ernest	<b>Junction City</b>
Russell, Marion Fore			Brethour, Leslie J.
Steffen, Marvin Omar	<b>Herington</b>	<b>Hutchinson</b>	Carr, Robert Manning
Wheeler, LeRoy J.	Danielson, Arthur David	Armitage, Albert Constant	Carr, Walter Austin
White, Charles L.	Gilliland, James Orth	Barnes, Harold Reuben	Lanning, Robert Joseph
Zugg, Clark William	Loomis, Sydney P.	Blank, John Nicholas	Minnick, Charles Vernon
	Marshall, Harley	Blasdel, Harry Emert	O'Donnell, Arthur Edwin
<b>Green</b>	Nichols, Schuyler	Boyd, Charles Arthur	O'Donnell, Frederick William
Morton, Warren Ralph	Petersen, Daniel	Brownlee, John James	Smiley, Edward Archibald
	Reichley, Elmer Jacob	Chickering, George Abbot	Smiley, William Arthur
<b>Greenleaf</b>		Fernie, Robert William	Steadman, Leonard Somerville
L'Ecuyer, Lynn Joseph	<b>Hesston</b>	Fitzgerald, Edward Lawrence	Van Pelt,
Snyder, Z. Hosea	Brenneman, Frederick Stauffer	Foltz, J. Eliot	Clifford Alexander, Jr.
		Forney, Lee Ole	
<b>Greensburg</b>	<b>Hiawatha</b>	Glaser, Leland Forrest	<b>Kanopolis</b>
Deal, Edwin Perle	Conrad, Paul Edgar	Greever, Boyd Lorens	Davis, George Fred
Friesen, Florence Coopridre	Crews, Cora Snyder	Hall, Clarence Walter	
McLaughlin, James Arthur	Duckett, Thomas Gaillard	Hempstid, Irl Edwin	<b>Kansas City</b>
Updegraff, Chester Deric	Heryford, Jacob R.	Jarrott, John Bennett	Abrams, William W.
	Lawrence, Edward King	Jones, Robert Young	502 Huron Bldg.
<b>Halstead</b>	Meidinger, Ray	Jones, Sam	Alexander, Clyde William
Chesky, Victor Ernest	Nichols, Roscoe Townley	McNair, Charles Francis	1512 North Fifth
Foster, Thomas Lloyd	Steinhauser, William Michael	Mundell, Minuette Smith	Algire, William Hackney
Gradinger, Billens C.		Mundell, Walter Newton	510 Bennett Building
Hertzler, Arthur Emanuel	<b>Highland</b>	Paine, George Edward	Allen, Lewis George
Koeneke, Irene Anita	Harp, Robert Franklin	Pinsker, Jacob A.	811 Huron Building
Koops, Franklin Walter		Quiring, Walter Otto	Allen, Max Scott
Peckenschneider, Lloyd Orval E.	<b>Hill City</b>	Richmond, Louise Finlaw	4155 Eaton
Peterson, Emmitt Eugene	Law, Lottie R. Findley	Scales, William McVey	Andrews, William Wallace
Rhoades, Gordon Howard	Vesper, Vernon Alfred	Schoor, William Frederick	1603½ North Tenth
Walsh, William Stanley		Schrant, John Herman	Angle, Lewis Winston
Westfall, George Arthur	<b>Hillsboro</b>	Stewart, Henry Milton	308 Huron Building
	Etzen, Abraham Clement	Stewart, Richard A.	Asbell, Edward Lawrence
<b>Hanover</b>	Janzen, Herman Ferdinand	Stone, Gordon Earl	411 Huron Building
Hurtig, Henry George		Walker, Guy R.	Bantleon, Verne Henry
	<b>Hoisington</b>		444 North Eighteenth
<b>Hardtner</b>	Atkin, Edward Henry, Jr.	<b>Independence</b>	Barker, John Ethan
Terry, Jack Trebling	Brown, Thomas Jacob	Bates, Gerald Chapman	626 Minnesota
Yasuda, Hiroshi	Robison, Corbin Ellis	Bullock, Harold Oliver	Barney, Louis Frank
		Carter, Rodney Gilbert	200 Brotherhood Block
<b>Harper</b>	<b>Holton</b>	Clark, Porter M., Jr.	Barry, William Burnett
Dieter, Charles August	Moser, Ernest Clyde	Furgason, Earle Ruben	Betz, John Sherrill
Joslin, Leeman Charles	Moser, Roy Hector	Gleason, Kenneth Jack	611 Huron Building
Springer, Ralph W.	Shoyer, Mayer	Gollier, Charles Edward	Billingsley, John A.
	Wyatt, Charles Arthur	Goodloe, Hart	2024 Washington Blvd.
<b>Harveyville</b>		Hughbanks, James Gard	Blount, William Marshall
Tomlinson, Louis Monroe	<b>Hope</b>	Miner, Elmer A.	436 Minnesota
Youngman, Charles L.	Klingberg, William August	Shepard, Chester Orville	Boone, Armer Eugene
	Turner, Herschel Roy	Smith, Thomas Elmo	100½ North Sixth
<b>Haven</b>		Swanson, John Theodore	Bowser, John Francis
Haines, Chester Wayne	<b>Horton</b>	Williams, Charles LaFayette	4221 Kenwood
	Edmonds, George Marius		Braithwaite, Harold Musgrave
<b>Havensville</b>	Edmonds, Leland Creason	<b>Iola</b>	10 North James
McManis, James Edwin		Campbell, Robert Finley	Bresette, Louis Lafe
	<b>Howard</b>	Chambers, Adelbert Royal	314 Brotherhood Block
<b>Hays</b>	DePew, Frank L.	Christian, Robert Ord	Brown, Caroline Christel
Bethhauser, Joseph Rudolph	Harner, Romeo Catlin	Garlinghouse, Orestes Lucien	University of Kansas Hosps.
Blake, Clyde Dale		Leavell, Frederick L. Bradford	

- Burger, Julius Anthony  
820 Shawnee Avenue
- Busenbark, Ray  
224 Brotherhood Block
- Calkins, LeRoy Adelbert  
University of Kansas Hosps.
- Campbell, Charles Albert  
28 South Baltimore
- Carey, Francis Stephen  
1014 Huron Building
- Claypool, John Gordon  
2631 Armstrong
- Coady, Charles Cromer  
1120 North Washington
- Coburn, Clay Ephraim  
430 Brotherhood Block
- Coffin, Benjamin E.  
2130 State Avenue
- Davidson, Oscar Wilford  
417 Huron Building
- Davis, Christopher Gates  
Kresge Building
- Davis, George William, Jr.  
St. Margaret's Hospital
- Day, Hughes Winfield  
309 Huron Building
- Delp, Mahlon Henry  
5620 Walnut
- Dillon, Tony Guy  
905 North 7th
- Dreher, Henry Samuel, Jr.  
University of Kansas Hosps.
- Dyer, William Holmes  
1968 North 3rd
- Enders, Edwin Wray  
University of Kansas Hosps.
- Evans, Joseph George  
703 Huron Building
- Feehan, William Joseph  
308 Huron Building
- Fisher, Lewis Shepard  
1501 South 22nd
- Floersch, Hubert Michael  
407 Huron Building
- Franklin, Glenn Coover  
University of Kansas Hosps.
- Fulton, James Albert  
1829 Washington Blvd.
- Gill, John Montgomery  
1932 North 5th
- Gloyne, Louis Boucher  
Brotherhood Building
- Goldblatt, Bernard  
206 Huron Building
- Gray, George Morris  
1305 Hoel Parkway
- Gripkey, Clarence Anthony  
1607 Minnesota
- Grosdidier, Edward Joseph  
1010 Huron Building
- Haas, Karl C.  
1533 South 21st
- Hamilton, Tom Reid  
University of Kansas Hosps.
- Harms, Albert Charles  
840 Barnett
- Hassig, Cecil Edward  
409 Huron Building
- Hassig, John Franklin  
804 Huron Building
- Haus, Loren Wilson  
University of Kansas Hosps.
- Hedge, Mayro Oran  
1001 Central Avenue
- Hesser, Herbert Harold  
905 North 7th
- Hiebert, Peter E.  
808 Huron Building
- Hill, Lee Verne  
528 Brotherhood Building
- Hobson, George Henry  
804 Huron Building
- Holter, Harold Vincent  
1211 North 7th
- Isenberger, Robert Murray  
University of Kansas Hosps.
- Johnson, Edward Albert  
631 Everett Avenue
- Kassel, Henry William  
416 Brotherhood Building
- King, Harry Walter  
502 Huron Building
- Knight, Durrell Keeling  
626 Minnesota
- Krall, Paul Morton  
811 Huron Building
- Kubin, Doris Aline  
Huron Building
- Laing, Maurice Vincent  
1200 Huron Building
- Laing, Stanley Glen  
700 Central Avenue
- Lee, Robert Louis  
Argentine Memorial Bldg.
- Leger, Lee Herman  
University of Kansas Hosps.
- Lindquist, Paul Albert  
619 Ann
- Lorhan, Paul Herman  
University of Kansas Hosps.
- Love, William Albert  
1820 North 3rd
- Lowman, Richard Clark  
704 Huron Building
- Lucas, Robert Thomas  
750 Minnesota
- Luke, John Henry  
1607 Minnesota
- McConchie, James Estil  
University of Kansas Hosps.
- McKean, Willis Hirst  
1200 Huron Building
- McLaughlin, Chilton W.  
1007 North 6th
- McWilliams, Cline Van Sandt  
707 Huron Building
- Mabie, Lot Dalbert  
804 Huron Building
- Manley, Joseph Warren  
606 Huron Building
- Martin, Gordon Mather  
University of Kansas Hosps.
- Martin, John Neal  
Medearis, Donald Norman  
1200 Huron Building
- Mielke, Charles Harry  
1636 Woodlawn Boulevard
- Miller, Eldon Stiles  
1441 South 33rd
- Miller, Herbert Chauncey  
University of Kansas Hosps.
- Millis, Earl Romaine  
1517 Huron Building
- Mills, Fred Edward  
St. Margaret's Hospital
- Montgomery,  
Charles Ellsworth  
1441 South 33rd
- Mott, James M., Jr.  
1131 Hilltop
- Mullen, Clifford John  
424 Brotherhood Building
- Myers, Robert William  
University of Kansas Hosps.
- Nash, Francis James  
Huron Building
- Nason, Zacharias Miles  
406 Brotherhood Block
- Neighbor, Ernest Garland  
2245 Fieldston Road
- Neighbor, Gaylord Pritchard  
3119 Strong
- Nesselrode, Clifford Calvin  
1200 Huron Building
- Newman, Robert Lewis  
University of Kansas Hosps.
- Nothnagel, Arnold Fred  
712 Reynolds Avenue
- Orr, Thomas Grover  
University of Kansas Hosps.
- Palmer, William Rolland  
602 Minnesota
- Pearson, Walter J.  
4221 Brown
- Peters, Glenn R.  
1200 Huron Building
- Phillips, Frederick Nathaniel  
1932 North Fifth
- Pickett, William H.  
619 Ann
- Plett, John Victor  
Bethany Hospital
- Rautert, Julius Henry  
1800 Central Avenue
- Reeves, Eugene Albert  
1607 Minnesota
- Regier, Henry Lewis  
704 Huron Building
- Rettenmaier, Albert Joseph  
1010 Huron Building
- Richards, George William  
15 South 17th
- Richeson, Rae Arthur  
322 Brotherhood Building
- Rieke, Frank Arthur  
3288 Coronado
- Riley, Ray Burney  
804 Huron Building
- Robbins, Agnes Louise  
St. Margaret's Hospital
- Rook, Lee Emerson  
3214 Strong
- Rubbra, Jean Olive  
St. Margaret's Hospital
- Russell, Guy Jewell  
640 Kansas Avenue
- Ryan, Maurice James  
310 Huron Building
- Ryan, Michael Joseph  
310 Huron Building
- Schulte, Emmerich  
968 Central Avenue
- Sereris, Edgar Paul  
712 Reynolds
- Shaad, Dorothy Jean  
Huron Building
- Shepherd, Glen Reid  
2401 Washington
- Sims, Thomas Jackson, Jr.  
930 Cleveland Avenue
- Soanes, Jabez George  
400 Minnesota Avenue
- Spake, LaVerne B.  
322 Brotherhood Block
- Speer, Frederic Aiken  
2601 Parallel
- Speer, Leland N.  
1022 Hoel Parkway
- Speer, Newton C.  
602 South Packard
- Steinzeig, Alfred Sidney  
628 Packard
- Summerville, Ward White  
Bethany Hospital
- Thompson, Solomon Henry  
1512 North 5th
- Tice, Galen Martin  
University of Kansas Hosps.
- Underwood, Harry Anson  
3926 Fisher
- Wahl, Harry Roswell  
University of Kansas Hosps.
- Walker, George Alvin  
University of Kansas Hosps.
- Walker, Maurice Andrew  
1417 South 37th
- Weaver, James Branson  
5249 Missionwood
- Weber, Clarence Jacob  
University of Kansas Hosps.
- West, Charles Omer  
414 Huron Building
- Wheeler, Howard M.  
552 Minnesota
- Williams, Ernest Dyer  
804 Huron Building
- Wilson, Lewis Barrick  
5500 Fairway Road
- Wilson, Sloan J.  
4401 Cambridge
- Young, Chester Lee  
Kensington
- Hartman, Buford  
Kincaid
- Stone, Francis M., Jr.  
Kingman
- Baldridge, Richard Edwin
- Burket, George Edward, Jr.
- Haskins, Henry Edgar
- Longenecker, Charles Willard  
Kinsley
- Johnson, Charles Hans

Schrader, Lewis Milward Unruh, Rudolph Theodore	Sterett, David Robb Suwalsky, Adelbert L.	Manhattan	Miltonvale
<b>LaCrosse</b>	Vaughn, Clarence Keane	Ball, Ralph Garnett	Kimble, Thaddeus Carey
Attwood, John Edward Singleton, Walter James	Voorhees, Gordon Stanley	Bascom, Kellogg Finley	<b>Mineral</b>
<b>La Cygne</b>	Webster, Paul Reichard	Bestgen, Fred Peter	Wolohon, Harry Cofman
Morrison, Scott D.	<b>Lebo</b>	Burns, Warren Whitcomb	<b>Minneapolis</b>
<b>Lansing</b>	Hunter, Kenneth Ross	Cave, Robert Russell	Foutz, Homer Sylvanius
Moore, Robert Hollingworth	<b>Lenora</b>	Clarkson, William Henry	Haerle, Edward Jacob
<b>Larned</b>	Steichen, Edward Francis	Colt, James Dennison	Harvey, Fredric Everett
Blount, Justin Alexander Coughlin, Samuel Thomas Dillon, John Alfred Frazer, Thomas Roydan Morris, Earl Fayette Naramore, James Thomas Shepard, LeRoy Wesley Sheppard, Cyril Evan	<b>Leon</b>	Colt, James Dennison, Jr.	Wooster, Winifred Viers
<b>Lawrence</b>	Last, Harry	Colt, James Dennison, V	<b>Mission</b>
Anderson, Arthur Sam Auchard, Virgil Marion Belot, Monti Louis, Jr. Boyden, Mary Scarborough Canuteson, Ralph Irving Chambers, Harry Leslie Clark, Margaret Goode Clark, Ray Albert Dorsey, Dennis Basil Edmiston, Roy Hammond Holmes, John Allison Hutchinson, Robert Bruce Isaacs, Fred Rife Johnson, Chase Benjamin Jones, Hiram Penfield Lane, Henry Wallace Liddy, Eugene Daniel, Jr. Lins, Beatrice Martha Mott, James Mabbitt Nelson, Carl Ferdinand Nelson, Lois Margaret Nelson, Richard Oldfield Nelson, William Oliver Owen, Elijah Mobry Palmer, William Robert Pendleton, Raymond Lancing Powell, Lyle Stephenson Roach, Harry Marshall Schwegler, Raymond Allen Sherwood, Noble Pierce Sudler, Mervin Tuban Van Noy, Harvey Elijah Woodard, Parke Harold Zimmer, Louis Kurt	<b>Leonardville</b>	Charles Roosevelt	
<b>Leoti</b>	Lafene, Benjamin William	Marker, Daniel Isaac	Carbaugh, Kenneth Wayne
<b>Le Roy</b>	Ott, Leroy S. S.	Melchert, Harold Bruce	Steegman, Albert Theodore
Wells, Max Welton	<b>Lewis</b>	Nelson, Barrett Arthur	<b>Moline</b>
Meckfessel, Frank G. H.	<b>Liberal</b>	Reitzel, Walter Maywood	Scimeca, William B.
Baty, Fred Daniel Hilbig, Albert Lionel McCreight, Eugene James Mays, Charles Oscar Prochazka, Otto Frank L. Zimmerman, Leon Ward	<b>Lincoln</b>	Schoonhoven, R. Grover	<b>Moran</b>
Kerr, Lambert A. Songer, Herbert Lee	<b>Lincolnville</b>	Schwartz, Willard Chester	Nevitt, Rollin Roy
DeMand, John Wesley	<b>Lindsborg</b>	Snook, Robert Rufus	<b>Mound City</b>
Holwerda, George William Murfitt, Malcolm Clement	<b>Louisburg</b>	White, Thaddeus Hug	Mills, Lewis Dell
Ferrel, Jesse Vanlandingham Gatley, Perla Frank Kelly, John William	<b>Lyndon</b>	Wilen, Carl John W.	<b>Mound Ridge</b>
Beasley, Charles Wesley Smith, French Miles	<b>Lincolnton</b>	<b>Mankato</b>	Baer, Daniel C.
Beyer, Louie John Bula, Ralph Elmer Hill, Edwin Ruthben Leonard, Roosevelt Schmidt, Albert William	<b>Lindsborg</b>	Raynolds, Elmer L.	Brenneman, Jacob James
Lose, Fred Davilla	<b>Louisburg</b>	<b>Marion</b>	Dyck, Cora Elizabeth
Wall, Victor Juble	<b>Lyons</b>	Goodsheller, George Jaroslav	Isaac, Elizabeth L.
<b>Maize</b>	Beyer, Louie John	McCandless, Orville Calnon	<b>Mound Valley</b>
Vermillion, John Selby	<b>Madison</b>	Melton, Ralph Robert	Wilson, Donald Ray
<b>Mahaska</b>	Bula, Ralph Elmer	Smith, Reuben Christopher	<b>Mulberry</b>
Wall, Victor Juble	<b>Meade</b>	<b>Marquette</b>	Nipple, Frederic E.
<b>Maize</b>	Hill, Edwin Ruthben	Walters, Byron Wesley	Sandidge, Allen Wilson
Vermillion, John Selby	<b>Medicine Lodge</b>	<b>Marysville</b>	Sandidge, James Gilmer
<b>Mahaska</b>	Leonard, Roosevelt	Haerle, Henry	<b>Mulvane</b>
Wall, Victor Juble	<b>Meade</b>	Hawkins, Robert	Buooa, Fern Ward
<b>Maize</b>	Schmidt, Albert William	Hutchison, Owen Ghormley	Carreau, Ernest R.
Vermillion, John Selby	<b>Madison</b>	McAllister, Robert Lewis	Wilcox, John Constantine
<b>Mahaska</b>	Lose, Fred Davilla	Randell, John Wesley	<b>Muncie</b>
Wall, Victor Juble	<b>Meade</b>	Wood, Orlin Pearl	Neas, Ingall Howard
<b>Maize</b>	Daugherty, Robert Melvin	<b>McCune</b>	<b>Nashville</b>
Vermillion, John Selby	<b>Medicine Lodge</b>	Wilson, Lawrence Smith	Waylan, Thornton Lewis
<b>Mahaska</b>	Grigsby, Kenneth Raymond	<b>McPherson</b>	<b>Natoma</b>
Wall, Victor Juble	<b>Melvern</b>	Dean, George Roland	Parker, Victor Robert
<b>Maize</b>	Kierulff, George Browning	Dyck, Arthur Hertzler	<b>Neodesha</b>
Vermillion, John Selby	<b>Melvern</b>	Finkle, Guy Ernest	McGuire, John W.
<b>Mahaska</b>		Green, John Dryer	Moorhead, Frank Allen
Wall, Victor Juble		Heaston, William Chamlis	Rich, William Tilton
<b>Maize</b>		Lohrentz, Abraham Martens	Sharpe, Orlan Dayton
Vermillion, John Selby		Lytle, Clinton Robert	Stephenson, Charles E.
<b>Mahaska</b>		Price, Vaughan Charles	<b>Ness City</b>
Wall, Victor Juble		Quantius, Rachel Houston	Parker, Dean Brownfield
<b>Maize</b>		Sohlberg, Robert, Jr.	<b>Newton</b>
Vermillion, John Selby		Walters, Orville Selkirk	Allen, Frances Ann
<b>Mahaska</b>		<b>Meade</b>	Burkett, Norman Andrew
Wall, Victor Juble		Daugherty, Robert Melvin	Enns, Jacob Harlow
<b>Maize</b>		<b>Medicine Lodge</b>	Fent, Leo Shriver
Vermillion, John Selby		Grigsby, Kenneth Raymond	Glover, Harold Mortimer
<b>Mahaska</b>		<b>Melvern</b>	Grove, John Axtell
Wall, Victor Juble		Kierulff, George Browning	

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Hertzler, John William		Pittsburg	Protection
Isaac, Arnold Gerhard		Bass, Lewis Napier	Glenn, Lyle George
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Martin, Melvin Cecil	Ebert, Adam John	Bena, James Henry	Poston, William Osee
Miles, Paul Wendell	Price, Claude Chandler	Benage, Clarence Harrison	
Morgan, Harold Eugene	Waxse, Isadore Joseph	Bierlein, Kenneth John	Quinter
Nanninga, John Benjamin		Braun, William Thomas	Hoover, Charles Oliver
Oltman, Theodore Voorhorst	Ottawa	Church, Harry Lester	Morris, Benjamin Smith
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Sills, Charles Theodore	Gollier, Robert Addison	Cowden, Alva Lemon	Attwood, George Arthur
Wheeler, James Albert	Henning, Calvin Wilbur	Erickson, Clarence Wilber	
	Henning, Joseph Regnald	Evans, John Frank	Richmond
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Moorman, Victor Reuben	Kaiser, Max Elliott	Haas, Louis Richard	Robinson
Norton	Lofgreen, Sylvia Young	Haigler, Frederick Herman	Van Voorhis, Van Curtis
Cooper, Arthur Edwin	Lofgreen, Victor Josiah	Hartman, William Vernon	Rossville
Kennedy, Francis David	Markham, Homer Everett	Kiehl, Otto B.	Miller, Henry Blackburn
Long, Carl Elijah	Speer, Louis Newton	Lyons, Dave Joseph	Smith, Clyde Stephen
Petterson, Cecil Edward	Trump, Frank Austin	McDonald, Ernest Cecil	
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Smith, Roy Kenneth	Young, Pearl Raymond	Marchbanks, Howard E.	Tapscott, John Hadley
Stephenson, Walter		Markham, Robert Marion	
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Norway	Grayson, Roy David	Montee, Clarence Martin	Cramm, Carl John
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Oak Hill	Maser, George Roland	Newman, Carl Sullivan	Koerber, Paul Ernst
Need, Omar Ulysses		Newman, Clifford Blenn	Pettijohn, Walter Johnston
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Nelson, Chester Martin	Paola	Rush, Floyd Harold	
Olathe	Brown, William	Sharp, Oscar	Sabetha
Albaugh, Houghiton Samuel	Elson, Vervy J.	Smith, Chester Herbert	Brown, Virgil Evan
Beebe, Edmer	Fisher, Charles Andrew	Stelle, Harry Lewis	Haynes, Arthur Haislet
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Onaga	Van Pelt, Clifford Levi	Plainville	Rucker, Martin Joseph
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Piper, Dorus H.	Landes, George Albert	Potwin	
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Osborne	Miller, Charles Henry	Pratt	Smith, Orval Lewis
Henshall, James Edgar	Morrow, Nelson Case	Black, Cyril Victor	
Jordan, Ralph Ensign	Nash, Arthur Richard	Campbell, John Ross	Salina
Miller, Walter W.	Pace, John David	Christmann, Marshall E.	Anderson, Donald Andrew
	Rose, Ralph James	Cochran, Athol	Armstrong, Carroll Dunham
	Ruble, Mirl Calvin	Hill, James Noah	Armstrong, Carroll William
	Stevenson, Onnie Earle	Ireland, Edwin McCormick	Brittain, Oman Reuben
	Urie, Rolland William	Pitman, Will D.	Brown, Manuel Jay
	Woodhull, Maurice Welch	Thorpe, Francis Adams	Brown, Porter
			Brungardt, Balthasar Aloysius
Peabody	Johnson, Edward Hinman	Prescott	Cheney, Ralph Edwin
	Tate, Wendell Maurice		
Penalosa		Haughey, George Cornelius	
	Knappenberger, Roy C.		

Dodge, Mark	Relihan, Francis Henry	Beller, Willis Leon	Erickson, Oscar Leonard
Dreher, Henry Samuel	Watts, Victor Everitt	501 Central Building	724 Mills Building
Eaton, Leslie Fay		Beverley, George William B.	Ernest, Elvenor Ann
Fitzpatrick, Charles Mooney		209 Central Building	710 Mills Building
Ganoung, Edwin Grant		Billings, Alva Edgar	Farley, John Aloysius
Harvey, Ernest Edward		30th and Topeka, Route 1	Santa Fe Hospital
Harvey, John King		Bishoff, Mark Lincoln	Finney, Guy Alpin
Hatton, Lloyd William		Santa Fe Hospital	720 Mills Building
Jenney, Charles Maxwell		Blake, Henry Seavey	Floersch, Michael A.
Loyd, Perry Armstrong		910 Natl. Reserve Bldg.	500 Central Building
Martin, Oliver Lilbourn		Boggs, Frank Clinton	Ford, Harold Vandiver
Mitchell, John Charles		606 Mills Building	Winter General Hospital
Moses, Howard Nelson		Borst, William Lewis	Funk, Edward Dallas
Nelson, Laurence Strong		927 North Kansas Avenue	633 Kansas Avenue
Neptune, Harold Everett		Bowen, Clovis Walker	Funk, Ralph L.
Neptune, John Wesley		212 Central Building	308 Natl. Reserve Bldg.
Padfield, Earl George		Bowen, Harry Justus, Jr.	Gill, Merton Max
Rueb, Andrew Edwin		212 Central Building	3617 West Sixth
Schaefer, Leo Joseph		Bowen, James Dinwiddie	Glauner, Frederick Earl
Seitz, George		212 Central Building	S.B.A. Hospital
Sheldon, Richard Robert		Bowen, William Francis	Gootee, Herbert William
Simpson, James Augustine		801 Western	605 Mills Building
Simpson, James Colbert		Boyd, Spencer Harwood	Greenwood, Edward David
Snyder, Maurice		708 Natl. Reserve Bldg.	3617 West Sixth
Sutton, Edgar Milton		Brier, Archibald John	Greer, Richard Henry
Vermillion, Earl Leroy		717 Mills Building	627 Mills Building
Walker, Oliver D.		Carr, David Decatur	Hagler, Carl William
		Municipal Building	201 Natl. Reserve Bldg.
<b>Satanta</b>		Casto, James Frederick	Hammel, Seth A.
Ungles, James Bonner		Santa Fe Hospital	114 West Eighth
		Cavanaugh, John W.	Hatfield, William J.
<b>Savonburg</b>		Winter General Hospital	1135 College
Morgan, George William		Chapman, Florence P. Simms	Hayes, Harry James
		State Hospital	Winter General Hospital
<b>Scandia</b>		Chappell, Ewin Summers	Heckart, Elliott Tate
Haggman, Charles Victor		Winter General Hospital	610 Central Building
		Choy, James King L.	Helwig, George Freeman
<b>Scott City</b>		601 Natl. Reserve Bldg.	704 Mills Building
Kippenberger,		Clark, Herbert Lee	Hobart, Wilson Keith
Rinhart Ferenand		825 Kansas Avenue	623 Mills Building
Palmer, Henry Preston		Clark, Orville Richolson	Hogeboom, Henry Buckmaster
		515 Mills Building	1299 Pembroke
<b>Sedan</b>		Cohen, Louis	Joss, Chester Earle
Calhoun, Fred		630 Kansas Avenue	609 Natl. Reserve Bldg.
Marrs, Edward Arlington		Cox, Seth Leroy	Keaney, Robert Emmett
Smith, Carl Marquis		824 Kansas Avenue	S.B.A. Hospital
		Crabb, John Adam	Kerley, Granvil Lessen
<b>Sedgwick</b>		630 Kansas Avenue	207 Central Building
Buley, Delmond Gilbert		Craig, Alexander Crawford	Kinnaman, Clarence Horace
Hymer, Edison Staton		National Reserve Building	State Board of Health
		Crank, Henry Harlan	Kirkpatrick, Hazen Leon
		3617 West Sixth	715 Mills Building
<b>Selden</b>		Curry, Lewis Allison	Knight, Robert Palmer
Fleckenstein, August P.		517 Mills Building	3617 West 6th
		Davis, Harry Joseph	Krehbiel, Bertrand Isaac
<b>Seneca</b>		709 Natl. Reserve Bldg.	910 Natl. Reserve Bldg.
Barnes, Conrad Marden		Decker, Ernest Hamilton	Lattimore, John Lee
Gray, Harry Palmore		724 Mills Building	618 Mills Building
Mollohan, Morgan Luther		Dickson, Ross Dale	Lawson, Dwight
Snyder, Henry Galen		902 Natl. Reserve Bldg.	509 Natl. Reserve Bldg.
		Dunlap, Richard Leonidas	Lerrigo, Charles Henry
<b>Sharon Springs</b>		Santa Fe Hospital	824 Kansas Avenue
Brakebill, Martin Luther		Eckles, Lucius Elkanah	Lindsay, William Sharp
		901 Natl. Reserve Bldg.	1256 Western
<b>Shawnee</b>		Elkins, William Harry	Loveland, Forrest Leon
Sullivan, Henry Bradley		Emerson, Ralph Waldo	513 Mills Building
		1001 Natl. Reserve Bldg.	Lozoff, Milton
<b>Simpson</b>		Ensign, Paul Roselle	3617 West 6th
Shaffer, Joseph		State Board of Health	
<b>Smith Center</b>			
Morrison, Hector			

McClintock, Edward Arthur 312 Central Building	Roberts, Howard Emerson 505 Natl. Reserve Bldg.	Valley Falls	Anderson, Samuel Milligan 1001½ West Douglas
McDonald, Orville Austin 503 Natl. Reserve Bldg.	Schaffer, Clarence Keisling 300 Central Building		Ashmore, Arthur Lawrence 601 Orpheum Building
McNaughton, James Harvey 911 Kansas Avenue	Scott, William Benjamin 334 Kansas Avenue	Victoria	Baker, Elven O. 213 Orpheum Building
Maker, Louis Edward State Hospital	Shaw, Joseph Cook 1401 Buchanan		Bartlett, Wayne Chrispien 729 Beacon Building
Marcotte, Oscar Francois 605 Natl. Reserve Bldg.	Siever, Charles M. 1731 Buchanan	Wakeeney	Beaver, James Leland 617 First National Bldg.
Marshall, Bromell Moeser 723 Mills Building	Silvert, Meyer Winter General Hospital	Herrick, William Yetter	Bell, Perry Marshall 1025 North Ohio
Martin, Thaddeus Philip 122 East 4th	Sloo, Milo Goss 618 Mills Building	Wakefield	Bence, Arthur Edgar 801 Brown Building
Mathews, Hugh Howard 839 North Kansas Avenue	Smith, Leo Albert 508 Central Building	Walnut	Berger, John Philip 509 Brown Building
Mayes, William Fred State Board of Health	Spann, Frederick Nimrod 330 Kansas Avenue	Walton	Biermann, William John 709 Union National Bldg.
Menninger, Charles Fredric 3617 West Sixth	Stahl, Clare William 826 Kansas Avenue		Bowman, Lang Fulton 710 Schweiter Building
Menninger, Karl Augustus 3617 West Sixth	Stephens, Charles Benedict State Hospital	Wamego	Brown, Cyril Carroll 815 Beacon Building
Menninger, William Claire 3617 West Sixth	Stewart, James Graves 627 Mills Building		Brownell, Morton Emmons 1019 First National Building
Michener, William Ernest 406 Central Building	Stock, Karl William 523 Mills Building	Washington	Buck, Ben H., Jr.
Millard, Samuel Thomas 633 Kansas Avenue	Taggart, Floyd Cornelius 509 Natl. Reserve Bldg.		Burkhead, Carl Roscoe 703 Brown Building
Miller, Milton Bradford 200 Central Building	Trees, Clyde Beverly National Reserve Building		Callahan, William Paul 1108 Brown Building
Mills, William Merrill 515 Mills Building	Turgeon, Leo Victor 608 Central Building		Campbell, Garland Leroy 214 Orpheum Building
Morris, Harold Thoës 719 Mills Building	Vest, Frederick Eugene 605 Mills Building	Waterville	Carson, Paul Congleton 401 North Emporia
Newman, Malcolm C. 603 Mills Building	Wakeman, Don Conklin 312 Central Building		Carter, Earl Dwight 1014 Central Building
Nicoll, David Thomson 829 Buchanan	Walker, William James Santa Fe Hospital		Cheney, James William 702 Schweiter Building
Northrup, John Fredrick 314 Natl. Reserve Bldg.	Warriner, William Lucian 310 Central Building	Wathea	Chipps, James Edward 910 Schweiter Building
O'Connor, Thomas Augustine 600 Natl. Bank Bldg.	Westfall, George Arthur, Jr. 3611 West Eighth		Christmann, Paul 303 Brown Building
Owen, Arthur Kirk 720 Mills Building	Wiedemann, Eugene Maximilian State Hospital	Wellington	Clapp, Raymond Carlton, Jr. Clark, Howard Charles 706 Orpheum Building
Parker, Bernard Barney S.B.A. Hospital	Wiksten, Vernon Cornelius 902 Natl. Reserve Bldg.		Clark, John Donavan 706 Orpheum Building
Perry, Middleton Lee State Hospital	Winkle, Vernon Melvin Municipal Building		Coffman, John Franklin 900 North Topeka
Pfuetze, Robert Emil 609 Natl. Reserve Bldg.	Woods, Harold Harrison 501 Central Building		Coleman, John Spurgeon 623 First National Building
Powell, Paul Mahlon 823 Kansas Avenue	Worthington, Robert Langhorne 3617 West Sixth		Conwell, Daniel Vincent 608 Brown Building
Powers, Harold Wayne 705 Natl. Reserve Bldg.	Zagaria, James Francis Santa Fe Hospital	Wellsville	Cooper, Everett Lucius 808 Brown Building
Pusitz, Manuel Elias 307 Central Building			Corrigan, George Francis 902 Brown Building
Pyle, Lucien Robert 910 Natl. Reserve Bldg.	Troy		Cowles, George Edwin 902 Brown Building
Raines, Omer Marvin 703 Natl. Reserve Bldg.	Cordonier, Alfred Edward Waller, Charles Edward	Westmoreland	Cox, Wilfred 617 First National Building
Ramsey, Carey Louis 1264 Jewell			Crittenden, Alden Larue 714 Orpheum Building
Reed, William Wallace 514 Mills Building	Turon		Crow, Ernest Whitaker 650 Hiram
Riedel, Robert Henry State Board of Health	Grieve, George Harry Thacher, Mowry Safford	Whitewater	Crumpacker, Leo Kyle 505 Brown Building
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	Miller, Riley Hess		
	Valley Center		
	Kasha, Robert Leonard		

- Dixon, Charles Hall  
1010 Schweiter Building
- Donnell, Louis August  
409 Schweiter Building
- Drake, Ralph Lafayette  
Brown Building
- Edgerton, Erastus Smith  
909 Schweiter Building
- Elnen, Walter Thomas  
715 Orpheum Building
- Emery, Frank Addison C.  
1029½ West Douglas
- Evans, John Lillie  
414 Farmers and Bankers  
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1258 Cleveland
- Fegely, Arthur Wesley  
501 Schweiter Building
- Fisher, James Brookbank  
714 Orpheum Building
- Friesen, Herman Elmer  
910 Brown Building
- Fritzemeier, William Henry  
509 Brown Building
- Frost, Earl Johnson  
913 Brown Building
- Gardner, Alfred E.  
1017 Central Building
- Gearhart, Alonzo Pitt  
402 K.F.H. Building
- Gillett, Wilbur Goodson  
201½ North Main
- Gouldner, René M.  
929 Beacon Building
- Gsell, George Franklin  
911 Beacon Building
- Gsell, Jacob Franklin  
911 Beacon Building
- Hagan, Condon Thomas  
No. 9 Hillcrest Apartments
- Hagan, Francis James  
927 Beacon Building
- Hagan, Martin  
927 Beacon Building
- Haworth, Edgar Sylvester  
914 Bitting Building
- Hellwig, Christian Alexander  
St. Francis Hospital
- Hibbard, James Sutherland  
501 Schweiter Building
- Hiebert, Abraham Ezra  
729 Beacon Building
- Hinshaw, Charles Theron  
705 Brown Building
- Hodson, Hervey Roland  
909 Schweiter Building
- Holt, Thomas Tallman  
701 First National Building
- Horn, Harry Wallace  
714 Orpheum Building
- House, Raymond George  
406 Schweiter Building
- Howard, Donald Osgood  
201½ North Main
- Howard, Robert Osgood  
906 Schweiter Building
- Hurst, Thomas Charles  
217 Derby Apartments
- Hyndman, Henry Harold  
602 Orpheum Building
- Jager, Thor Jager  
611 Beacon Building
- Johnson, Charles Nelson  
Beacon Building
- Johnson, Everett Wallace  
737 First National Building
- Johnson, Lester Elmer  
737 First National Building
- Kilbourn, Edward D.  
907 Schweiter Building
- Kirby, George Wightman  
305 K.F.H. Building
- Kiser, Willard Joyce  
505 Brown Building
- Kleinheksel, John Lewis  
714 Orpheum Building
- Knapp, Leslie Eugene  
402 K.F.H. Building
- Kunce, Fay Edward  
401 K.F. H. Building
- Lee, Carleton Harold  
1516 Laura
- Little, Lloyd Gilbert  
1005 Schweiter Building
- Loewen, Henry Homer  
529 Beacon Building
- Loewen, Peter Schellenberg  
3217 Victor Place
- Lowery, Thomas Andrew  
2227 South Oliver
- Loyd, Dale Ulysses  
401 K.F.H. Building
- McComb, Fred Jackson  
307 K.F.H. Building
- McEwen, Fred John  
714 Orpheum Building
- McKeown, Charles Davis  
414 Farmers and Bankers  
Building
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Box 1574
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843 North Broadway
- Magee, Charles Raymond  
1220 Union National Bldg.
- Maggard, Delano Irvin  
715 Orpheum Building
- Marshall, Hal Ellsworth  
201½ North Main
- Matassarin, Frederick William  
402 K.F.H. Building
- Maxwell, Robert Hayden  
501 Brown Building
- Meeker, Bruce Paul  
1220 Union National Bldg.
- Menehan, Frank Lionel  
912 Brown Building
- Michener, Robert Bryan  
428 South Broadway
- Milbank, George Edward  
629 Beacon Building
- Miller, Clyde Wortham  
509 Schweiter Building
- Mills, Charles Denton  
903 Schweiter Building
- Missildine, John Gurley  
906 Brown Building
- Montgomery-Short,  
Ruth Gertrude  
1009 First National Bldg.
- Morrison, George Brooks  
510 Schweiter Building
- Murphy, C. Henry  
214 Orpheum Building
- Murphy, Lyman Clements  
Wichita Hospital
- Nash, Newman Curtis  
310 Schweiter Building
- Nix, Lester Killough  
Derby Building
- Nodurft, Elmer J.  
529 Beacon Building
- O'Donnell, Harold Frederick  
510 Schweiter Building
- O'Donnell, Leonard Aloysius  
1225½ East Douglas
- Olson, Andrew Allen  
804 Brown Building
- Padfield, Robert Elmer  
811 First National Building
- Palmer, Dale Horace, Jr.  
302 Kaufman Building
- Palmer, Harold William  
905 Schweiter Building
- Parker, Clarence Avery  
202Greenwood
- Parmley, Charles Clifford  
St. Francis Hospital
- Pauley, Vern Lawrence  
1104 Brown Building
- Pennington, Katherine  
910 Schweiter Building
- Pile, Eugene  
2628 Mason Terrace
- Pohlman, John Francis  
3222 East English
- Putnam, Lyle Britain  
929 Beacon Building
- Rainey, Edward Carlyle  
615 Beacon Building
- Rainey, Norris Luetscher  
915 Beacon Building
- Reifsneider, Joseph Stanley  
719 Beacon Building
- Reitz, Harvey Edward  
Orpheum Building
- Revell, Arthur Joseph  
U. S. Veterans Hospital
- Rich, Oliver Smith  
919 Beacon Building
- Roberts, Louis Sidney  
414 Farmers and Bankers  
Building
- Rombold, Charles Roy  
1201 Union National Bldg.
- Rossitto, Anthony Francis  
Wichita Hospital
- Schiltz, Frances Helen  
1108 Brown Building
- Scott, Vincent Leslie  
509 Schweiter Building
- Scuka, Clayton Leon  
124 South Hillside
- Seydell, Ernest Morris  
1023 First National Bldg.
- Shaw, James Wallace  
502 Schweiter Building
- Siebert, Norman Clifford  
1401 Union National Bldg.
- Smith, Fredrick Donald  
501 Orpheum Building
- Spray, George Albert  
401 K.F.H. Building
- Stout, Samuel Lloyd  
311 Beacon Building
- Street, Glenn Q., Jr.  
608 Brown Building
- Sutter, Loe Albright  
611 First National Building
- Terrill, Edwin Harold  
609 First National Building
- Thomas, Charles Alfred  
1909 East Kellogg
- Thorpe, George Lawrence  
410 Schweiter Building
- Tihen, Henry Nelson  
714 Orpheum Building
- Tiller, Dean Jack  
410 Schweiter Building
- Tippin, Ernest Elwood  
601 First National Building
- Tonn, Gerhart Rudolph  
913 Brown Building
- Trees, Donald Paul  
816 Central Building
- Tucker, Claude C.  
401 Orpheum Building
- Updegraff, Alpha Daniel  
405 Schweiter Building
- Van Cleve, Joseph Vincent  
509 Brown Building
- Warren, Wirt Adrien  
Derby Building
- Weaver, Theodore Walker  
201½ North Main
- West, Ray Augustine  
1401 Union National Bldg.
- Wier, Charles Kirkland  
910 Schweiter Building
- Wittmann, Albert Frank  
118 East 21st
- Wolfe, James Edwin  
929 Beacon Building
- Woodhouse, Charles Leonard  
913 Beacon Building
- Winchester**
- Huston, Francis Wyatt
- Winfield**
- Bernstorf, Warren Frederick
- Brown, Harwin Joseph
- Carlsson, Erland Robert
- Chont, Laslo Kendey
- Dunbar, Milton James
- Fall, Norman Bryce
- Grosjean, Wendell Andrew
- Hall, Frederic Wilhelm
- Hawke, Charles Clifford
- Hood, Thomas Robin
- Jones, Harold Houston
- Norris, George Loren
- Ralls, Clayton Thomas

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<b>Illinois</b>			
<b>Indiana</b>			
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<b>Texas</b>			
<b>Washington</b>			
<b>Wisconsin</b>			
<b>West Africa</b>			

Huscher, Gladys

## EDITORIALS

### Congratulations!

Congratulations are in order for every member of the Congress of the United States who was in any way responsible for the retention "in committee" of all bills concerning compulsory health insurance and political medicine.

We admire your fortitude in the face of pressure from socialized and organized groups. We, also, believe in free enterprise. We, also, believe in the decentralization of power. We, also, cannot condone governmental restrictions and regimentation. We, also, believe in the American way of life. We offer you our congratulations.

### Shortage of Nurses

Throughout the nation there is an apparent shortage of applicants for nurses' training. Every day and several times a day over the national radio chains there are announcements requesting that those who are interested in nurses' training apply to their nearest hospital for information.

From the information that we are able to obtain, the only institutions that have sufficient applicants for their fall classes are those hospitals that have a university connection, where degrees in nursing education or hospital administration are obtainable.

At a meeting of the first district committee for the procurement of nurses a few weeks ago, the nursing shortage was discussed, not only that of graduate nurses but also of applicants for nurses' training. The concensus was that the shortage of graduate nurses is due to the present demands of service and veterans' hospitals, plus the usual factors of marriage, office positions, etc. It was thought that the small number of applicants for training is caused by the high wages being paid for inexperienced help in stores, factories and other places of employment.

It is unfortunate that we reach periods in the economic cycle in which both young and old, inexperienced and experienced, cannot look far enough into the future to realize that this is only a crest of a wave and that for every wave there is a trough. Those who build firmly now will be supported in the trough and will not be engulfed by the crest of the succeeding wave.

It is the duty of physicians to take care of the sick. In our present way of thinking, care of the sick is synonymous with hospitalization of the sick. If the sick are to be cared for in hospitals, it is necessary for the hospitals to have trained staffs. Therefore, it becomes the responsibility of phy-

sicians to aid in securing applicants for nurses' training.

There are many young women who have recently completed high school who would enter training with a little persuasion. These young women, or their parents, are your patients. Who could better put in a good word for the nursing profession than you? Now is the time to act. Don't gripe next winter, when you are busy, because you have to wait for a dressing or intravenous tray. Don't join the group of those who think that this era of prosperity is going to last forever. Put your shoulder to the wheel and push. Go out of your way to talk to some of these young women and their parents about nurses' training. This is a must. Just remember that if you let the hospitals down, it is you and your patients who will suffer.

### Poliomyelitis

The state of Kansas, with its neighbors, is again engulfed in an epidemic of that terrifying disease, anterior poliomyelitis. This disease is terrifying to physicians and laymen alike. It is terrifying to physicians because they are helpless in preventing the spread of the disease or the paralysis resulting from the disease. It is terrifying to laymen because they do not know how to protect their children from the disease. Also, for years to come, they will see the children of each epidemic grow into adulthood with residual damage, oftentimes severely disabling, of one epidemic.

In the light of present knowledge, we cannot prevent the spread of the disease. However, we can be prepared to take care of those who are so afflicted. Each year, through the March of Dimes, funds are collected to aid in the fight against infantile paralysis. A portion of these funds is retained locally. There are local committees whose job it is to plan for taking care of afflicted persons in future epidemics. But, like human nature and all committees, they are loath to function when there is no apparent need. So when an epidemic strikes there is no workable plan.

It is our suggestion that the local committees, each of which will undoubtedly have physician members, shall plan for future epidemics. Isolation units should be provided and equipped in local hospitals for the care of patients with this dread disease. We should get away from the idea that we can throw open the doors of our general hospitals and accept these patients when such hospitals are neither well equipped for their care nor for their isolation. It is not our contention that we should provide these units for the care of victims of infantile paralysis only. Since this disease occurs in epidemic form every two or three years, such provision would

## PRESIDENT'S PAGE

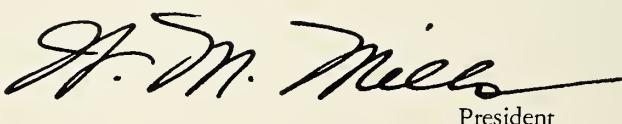
*To the Members of the Kansas Medical Society:*

Our veterans' program has become a project of major importance in which the Veterans Administration has cooperated in every detail. The Medical Service Center at Topeka will soon have twenty-two employees, including a second doctor, and teletype machines will be installed to speed service. Within a month, one hundred examinations will be processed daily and authorizations for service will be obtained far more quickly than at present. This will, incidentally, also increase payments made to physicians.

The other half of the agreement is our responsibility. It was known in advance that this program would be governed by regulations and that not everything would turn out ideally here any more than it will elsewhere. The difficulties, however, become insignificant when contrasted with the entire program, and for the most part they can be adjusted. Recommendations on ways in which this program can be improved will always be welcomed by the Committee on Veterans Administration Affairs.

We are pledged to provide state-wide service and service of the highest quality. The first half of our commitment has largely been accomplished in the splendid response from members all over the state. The second is an individual responsibility. Examinations must be carefully prepared if the rating board may evaluate the case in fairness to the Administration and to the veteran.

The Society contracted to supply service but it rests with each individual member to perform the work. The program, then, from one end to the other, depends entirely upon the sincerity with which we approach our work, the care we exercise in making examinations and upon our consideration of the veteran who is our patient.



H. M. Miles

President

be a wanton waste of money. It is our contention that many of the general hospitals of the state are not properly equipped to take care of and isolate any of the contagious diseases that require hospitalization. Such units, when provided, could be used for infantile paralysis, which is a summer disease, and at other times could be used for virus pneumonias, scarlet fever or any other type of contagious disease requiring isolation.

The communities in which we live look up to us to take care of their health problems. It is our responsibility to do the medical thinking. As members of local committees, we can direct the course of plans for future epidemics.

### Marion Trueheart, M.D.

Dr. Marion is gone. With his passing Kansas lost a great and noble person, the society lost an inspired leader and everyone who met him will miss his kindly friendship.

Gone are the intimate, personal characteristics that were his. The eternal pipe that when occasion demanded could be used as a gavel. The half-moon glasses hanging loosely far below his eyes. His open collar and his tie undone. His utter relaxation in a game of solitaire. His wry, quiet humor. His soft voice.

But he is here. Dr. Trueheart has not gone away. His patients, alive and well because of care he gave them, sense his presence. His inspiration to the doctors in this state has not departed. The untiring efforts he devoted toward cancer control will forever be a monument to his memory. His vast contributions to the medical society will make him a part of every project undertaken as long as the society exists. Within the mind Dr. Marion will stay here with us always.

The irony of his decease rests among the mysteries not given us to solve. After frenzied efforts during the war augmented by the additional burden imposed upon him from the society, he had only now decided to retire. There was fishing to be done in Mexican waters. There were meetings to attend. Friends to visit. Far away places to see. But Dr. Marion was wearier than he knew and these plans are unfulfilled.

He had grown weary serving as a physician, a living example in the highest tradition of his profession. The pioneering background from which he came was deeply engrained within him. The pride he felt for his work, his community, his nation—all these called him to efforts larger than many men experience. And so at last his great and noble heart grew still.

Missed he will be, yes, but missed with a respect and gratitude reserved for only a few. In one sense,

pride in having known him sublimates the loss. In another it seems to leave his place more vacant.

### Explanation to the Layman

Some weeks ago several members of the Kansas Medical Society visited with Dr. L. T. Brown of Denver. Dr. Brown has been writing material both for professional journals and for the lay press on federal legislation.

During the conversation Dr. Brown stated that he had written one article that has appeared in foreign language newspapers in Colorado. This was designed to acquaint foreign elements of the laboring classes, especially the Spanish speaking people, with the dangers of socialized medicine. The piece is admittedly elementary but is designed to appeal to persons without much formal education and, being the only attempt of its kind that has come to the attention of the Journal, it was believed interesting enough for repetition. The article, "All Is Not Good in the National Health Bill," follows:

"The Wagner-Murray-Dingell bill is very complex and contains some good sections and one very, very bad section. One good section provides federal government money to give medical aid to needy persons. The very bad section makes working people with income pay the government and then have a government doctor for their sickness.

"A government doctor is like the city doctor, too busy to take care of you; he runs in, leaves some pills and runs out to the next sick person. A government doctor is like the company doctor; the doctor is paid by the company whether he takes good care of you or not. A government doctor is like the army doctor; he is a friend of the officers of the army but he does not know each private in his company.

"When you pay your doctor yourself, the doctor is working for you. When the government pays all the doctors, then all of the doctors are working for the government and they are not working for you.

"Under this government scheme a man with \$1,000 income each year will pay \$15 to the government whether he is sick or not sick. Now, any man with so little pay as \$1,000 can get medical care free and does not need to pay \$15.

"Every part of the bill puts one man in Washington in charge of all parts of medical care. That is Totalitarianism; that is not American freedom. Doctors do not wish to all work for one man in Washington; doctors wish to work for each patient, to get each patient well.

"There are four different places in the bill which stop your free choice of doctor. 1. If your favorite doctor does not wish to be a government doctor, you cannot have him. 2. If your favorite doctor is a specialist, you cannot have him. 3. You cannot be sent to a specialist unless your government doctor says so. 4. The chief doctor in charge in Washington may limit the number of patients any government doctor may have, so you may have to change doctors.

"The one very bad section will be so bad for all sick people that the whole bill should be defeated and a new bill made with only the good parts of the Wagner-Murray-Dingell bill."

### Course in Clinical Allergy

The American Academy of Allergy announces an orientation course in clinical allergy to be held at Marquette University School of Medicine, Milwaukee, Wisconsin, October 7 to 11, 1946. The course is planned to acquaint physicians with basic principles of diagnosis and management of allergic diseases.

## Veterans Administration Agreement

The Medical Service Center will notify examining physicians whenever an examination is assigned. All necessary forms will be sent with the examination. Included also are instructions on procedure, a statement of tests that are required and, for the convenience of the examiner, a brief of the patient's medical history. The examination should be given as promptly as possible and an answer is required in each section of Form 2545.

Upon the completion of the examination the report is returned to the Medical Service Center at Topeka, from where it is sent to the regional office in Wichita. A rating board composed largely of lay persons studies this examination and on the basis of findings reported on Form 2545 evaluates the percentage of disability. All incomplete examinations and those lacking necessary information must be returned to the examiner. The committee desires that this will not be necessary and at weekly meetings reviews these forms before they are submitted to the rating board. Whenever the committee is in doubt, the form is returned to the examining physician for correction. It is hoped that all physicians will understand this to be a sincere effort on the part of the committee to present the Veterans Administration a uniformly high quality of service.

The second portion of the agreement represents treatment. Instructions previously mailed out declare that any approved physician may treat a veteran if authorization has been received. The physician must notify the Medical Service Center, giving enough information to identify the patient, a diagnosis of his illness and a plan for treatment. For male veterans, if the illness is service-connected in the opinion of the Veterans Administration, the treatment will be authorized. In the case of female veterans, non-service-connected illnesses may be treated providing hospitalization is required. For authorization write Veterans Administration Medical Service Center, 518 New England Building, Topeka, Kansas. In case of true emergencies the telephone may be used. Members are still frequently requesting the Veterans Administration to pay for medical care to veterans which in no way can be interpreted as service-connected. Such cases cannot be authorized.

Each month the Journal will print a summary from the Veterans Administration handbook to guide medical examiners. This material should be saved for future reference. Below is a summary of material pertaining to muscle injuries.

### Muscle Groups

The Schedule of Rating Disabilities provides description of and evaluations of disability for 23 regional groups of muscle injuries. To coordinate the report of examiners with these schedular criteria, these groups are named and their functions stated:

*Group I.—Extrinsic shoulder-girdle muscles.*—Trapezius, levator scapulae; serratus magnus. Function: Elevation of arm above shoulder level. Upward rotation of scapula.

*Group II.—Extrinsic shoulder-girdle muscles.*—Pectoralis major II (costosternal); latissimus dorsi and teres major; pectoralis minor; rhomboid. Function: Depression of arm from overhead to shoulder level. Adduction and flexion to side, forward and backward swing, inward rotation.

*Group III.—Intrinsic shoulder-girdle muscles.*—Pectoralis major I (clavicular); deltoid. Function: Elevation and abduction of arm to shoulder level. Forward and backward swing.

*Group IV.—Intrinsic shoulder-girdle muscles.*—Supraspinatus; infraspinatus and teres minor; subscapularis; coracobrachialis. Function: To protect the shoulder joint (supraspinatus, coracobrachialis), holding head in socket. Abduction, outward rotation (infraspinatus and teres minor).

*Group V.—Flexors of elbow.*—Biceps, brachialis, brachioradialis. Function: Flexion of forearm; supination (biceps).

*Group VI.—Extensors of elbow.*—Triceps, anconeus.

*Group VII.—Flexors of carpus and long flexors of thumb and fingers.*—Pronators.

*Group VIII.—Extensors of carpus, thumb and fingers.*—Supinators.

*Group IX.—Intrinsic muscles of hand.*

*Group X.—Intrinsic muscles of foot.*—(a) *Plantar.*—Flexor digitorum brevis; abductor hallucis; abductor digiti V, quadratus plantae, lumbricales, flexor hallucis, flexor digiti V, brevis abductor digiti V, opponens digiti V, interossei plantares. Function: Flexion of forefoot and toes. Support of arch.

(b) *Dorsal.*—Extensor hallucis brevis; extensor digitorum brevis; dorsal interossei. Function: Extensors of toes. Propulsion thrust in walking.

*Group XI.—Posterior and lateral muscles of the leg.*—Triceps surae (gastrocnemius and soleus); tibialis posterior; peroneus longus; flexor hallucis longus; flexor digitorum longus; popliteus. Function: Plantar flexion of foot. Flexion of toes, inversion of foot.

*Group XII.—Anterior muscles of the leg.*—Tibialis anterior; long extensors of toes; peroneus tertius. Function: Dorsal flexion of foot, eversion.

*Group XIII.—Extensors of hip and flexors of knee.*—Biceps femoris; semimembranosus; semitendinosus.

*Group XIV.—Anterior thigh group.*—Sartorius; rectus femoris; vastus externus; vastus intermedius; vastus internus; tensor vaginae femoris. Function: Extension of knee.

*Group XV.—Mesial thigh group.*—Adductor longus; adductor brevis; adductor magnus; gracilis. Function: Adduction of thigh, flexion of hip and knee.

*Group XVI.—Pelvic-girdle group.*—Psoas; illiacus; pectenous. Function: Flexion of thigh.

*Group XVII.—Pelvic-girdle group 2.*—Gluteus maximus; gluteus medius; gluteus minimus. Function: Extension of thigh, adduction of thigh, or tilting up of pelvis on opposite side. Postural support.

*Group XVIII.—Pelvic-girdle group 3.*—Pyriformis; gemellus (sup. or inf.); obturator (ext. or int.); Quadratus femoris. Function: Outward rotators of thigh and stabilizers of hip joint.

*Group XIX.—Muscles of abdominal wall.*—Rectus abdominis; external oblique; internal oblique; transversalis; quadratus lumborum. Function: Support of abdominal wall. Flexion and lateral motion of spine.

*Group XX.—Spinal muscles.*—Sacrospinalis (erector spinae and its prolongations in thoracic and cervical regions). Function: Postural support of body. Lateral and dorsal movements of spine.

*Group XXI.—Muscles of respiration.*—Thoracic muscle group.

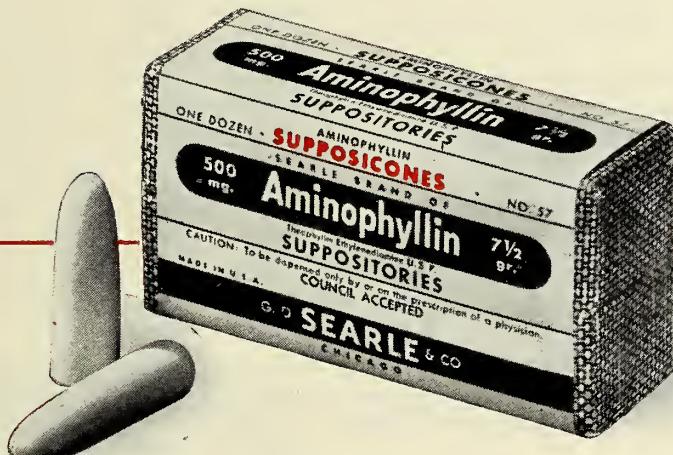
*Group XXII.—Muscles of the front of the neck.*—Trapezius I (clavicular insertion); sternomastoid; the hyoid muscles; sterno-thyroid; digastric. Function: Rotation and forward movements of head, respiration.

*Group XXIII.—Lateral and posterior muscles of the neck.*—Suboccipital; lateral vertebral and anterior vertebral muscles. Function: Lateral head movements.—*Manual for Medical Examiners of the Veterans Administration.*

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RESEARCH IN THE SERVICE OF MEDICINE

### Examinations for American Board

The next written examination (Part I) for all candidates for the American Board of Obstetrics and Gynecology, Inc., will be held in various cities of the United States and Canada on Friday, February 7, 1947. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the secretary by November 1, 1946. Candidates in military service are requested to keep the secretary's office informed of changes in address.

A number of changes in Board regulations and requirements were put into effect at the last annual meeting of the Board held in Chicago, Illinois, from May 5 to May 11, 1946. Among these is the requirement that case records must now be forwarded to the secretary's office from thirty to sixty days after the candidate has received notice of his eligibility for admission to the examinations for certification. At this meeting the Board also ruled that it will not accept the nine months residency as an academic year toward years of training requirements following the termination of the official period of intern and residency acceleration, April 1, 1946.

Applications are now being received for the 1947 examinations. Final examinations will be held in Pittsburgh, Pennsylvania, June 1-7, 1947. Complete information and application blanks may be secured from Paul Titus, M.D., Secretary, 1015 Highland building, Pittsburgh 6, Pennsylvania.

### Operative Surgical Clinics at Detroit

The International College of Surgeons announces that operative surgical clinics in 17 Detroit hospitals will be featured the first morning of the assembly of the United States chapter, October 21, 1946. Arrangements have been made to demonstrate advances in gastric, thoracic, biliary, intestinal, genito-urinary, and plastic surgery. The various specialties, ophthalmology, otolaryngology, gynecology, etc., will be included in the clinics, and there will be demonstrations of the modern treatment of burns, fractures and uses of wire in surgery.

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### Cancer Detection Clinic at Parsons

The cancer detection clinic at Parsons is the first such organization in Kansas to be placed in operation. It is a unique experience in which many of the doctors of that area participate.

This clinic is gratefully received by the community is shown by the fact that at its session of July 3, 117 patients were examined. Ninety-seven came for the first time and 20 were there for rechecks. It is reported that many more tried to come to the clinic but could not get in because physicians were unable to see more patients on that day. Among that number 10 were found to need treatment. Since the opening of this clinic about a month ago, 52 persons have been given x-ray treatment.

Another point of interest is that most of the members of the Labette County Medical Society are participating in this project. As of this date 10 doctors are in attendance. It is announced that in the future the clinic will be in operation a half-day each week.

### Civil Suits Filed

The Department of Justice in Chicago has recently filed civil suits against 52 doctors, practicing in a dozen states, and six wholesale optical firms. Four doctors practicing in Kansas are named in this action, according to announcements on the radio and in the lay press. In filing these suits the government charges the physicians with accepting rebates on glasses and repairs from the optical companies.

### Mississippi Valley Society to Meet

The Mississippi Valley Medical Society will hold its 11th annual meeting at the Hotel Jefferson, St. Louis, September 25, 26 and 27. Clinical teachers from the leading medical schools will conduct the postgraduate assembly in a program planned to appeal to general practitioners, and there will be 60 scientific and technical exhibits. Programs may be obtained from the secretary, Harold Swanberg, M.D., 209 W.C.U. building, Quincy, Illinois.

In connection with the meeting the Mississippi Valley Medical Editors' Association will hold its first post-war session on September 25.

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allergy or infection"*

Feinberg, S. M.: Allergy in Practice,  
Chicago, The Year Book Publishers, Inc., 1944, p. 502.

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## KANSAS PHYSICIANS' SERVICE

The high and increasing percentage of society membership enrolled as participating in Kansas Physicians' Service continues to be very gratifying. The total number is now 827. This places Kansas in top rank with the states showing active concerted support of the society-sponsored prepayment plans and presents a percentage participation much higher than exists in many of the states with older well established plans.

As increasing numbers of claims are filed for services rendered under KPS it becomes more important that all participating physicians' agreement cards be signed and sent to the Topeka office. The full schedule of benefits is paid only to participating physicians, as deduction of the five per cent service charge must be made from all payments to non-participating physicians.

Enrollment of subscribers increases steadily. A vigorous campaign for rapid enrollment has been deliberately withheld, chiefly to permit organizational development to insure adequate attention to and processing of new groups as enrolled and to accomplish proper prompt settlement of claims as filed. Nevertheless, enrollment is approximately 7,000. Development of an adequate staff in the administrative office is necessary for efficient operation. This now has been effectively achieved. Efficiency is furthered also by recent installation of elaborate equipment of International Business Machines. Consequently the stage is set for inauguration in the near future of an active campaign for membership, with salesmen promoting the plan in various areas, with dissemination of carefully prepared literature, and by newspaper advertising in territory being actively developed. It is, of course, impossible to blanket the entire state at once; but the plan is to cover selected areas to furnish representative coverage in all parts of Kansas.

The service is being actively utilized. Each month a larger group of claims is presented. Co-operation from physicians is excellent. Efforts expended in careful planning of the service are bearing fruit in the evidence of general understanding of the various features. Only occasionally must claims be rejected for such reasons as treatment of chronic or pre-existing conditions soon after enrollment. Such cases are eligible for care after eight months of membership.

Nationally, medical society-sponsored prepayment plans are developing rapidly. There are now 73 such plans, with 42 states having a plan either in operation or in active preparation. Interestingly, it is announced that two of those recently organized are patterned closely after the Kansas plan. The Division of Prepayment Plans, recently organized in the American Medical Association, is actively co-operating with the Associated Medical Care Plans to promote nation-wide coverage. Mr. Jay Ketchum, executive vice president of Michigan Medical Service, has been loaned on a part time basis to the Chicago office to further this program. He has travelled to many states to encourage and aid organization of plans, to furnish counsel, actuarial data and statistics. As a result rapid growth ensues. During 1945 enrollment in prepayment plans increased 114 per cent. The present year is showing even more rapid expansion, there now being only six states where action toward inauguration of a plan is yet to be started.

The Council on Medical Service of the American Medical Association is to be congratulated on its effective work toward activating and encouraging the movement. Among its aims are co-ordination of plans, effective reciprocal agreements, and granting of a seal of approval to approved plans. Some doubt has arisen as to whether the seal should be granted to society-sponsored plans operated by commercial insurance companies. Non-profit plans, such as in Kansas, are disturbed by the entrance of the profit motive and are disposed to object to the inclusion of such plans. Some states have, in fact, refused to join Associated Medical Care Plans if the commercial plans are approved. The question as yet is not resolved. Certainly it is desirable that all medical society-sponsored plans be not only *voluntary* but also *non-profit*.

### Attention: Returning Service Men

Many of our society members who have recently returned from military service are as yet unfamiliar with the intent and purpose, the mode of operation, and the general plan of Kansas Physicians' Service. Every effort has been made to supply this material promptly to each returning member. However, those who have not received this literature are urged to contact the Topeka office so the packet of informative material may be supplied. This will include the Participating Physician's Agreement card for signature and return to insure participation in the operation of the plan.

## DIAGNOSTIC CLINIC

HUGH JETER, M.D., F.A.C.P., A.S.C.P.

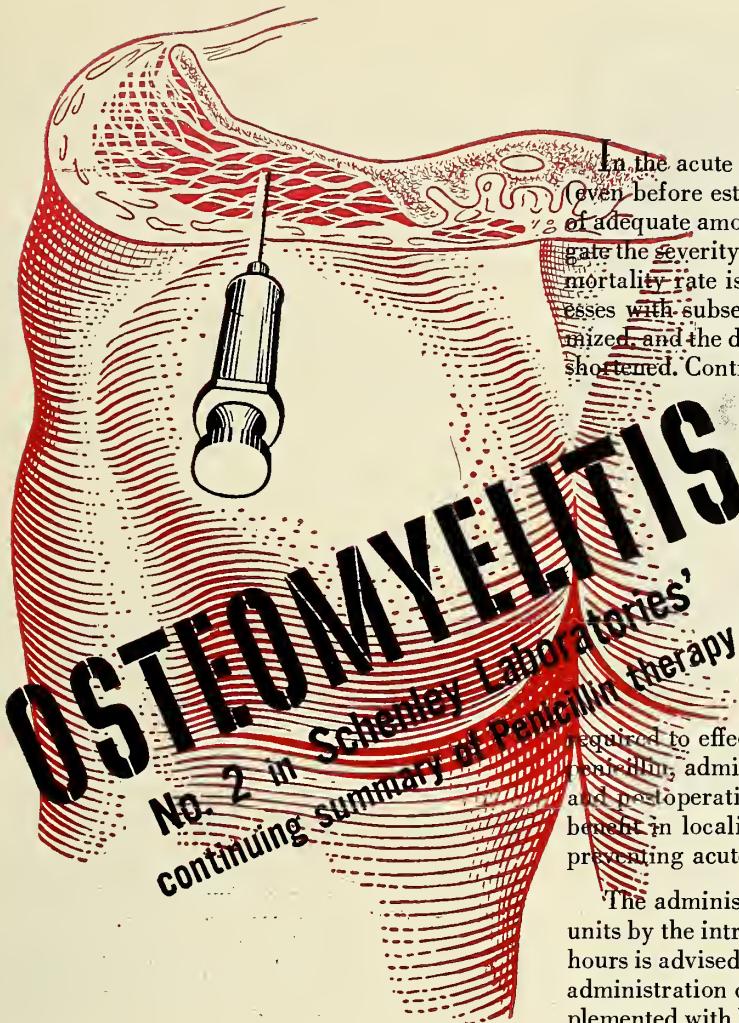
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In the chronic form, major surgery is usually required to effect a cure; however, penicillin, administered both preoperatively and postoperatively, is of inestimable benefit in localizing the infection and preventing acute exacerbations.

The administration of 20,000 to 40,000 units by the intramuscular route every 2 to 4 hours is advised. When necessary, parenteral administration of penicillin should be supplemented with local instillations of 25,000 to 50,000 units in a sterile solution two to three times daily. Due attention must be paid to surgical, supportive, and other measures when these are indicated.

To determine complete control and eradication of the infection, a prolonged follow-up period with frequent physical examinations and serial roentgenograms is advised.

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KEEFER, C. S. *Penicillin—Its Present Status in the Treatment of Infections: The Nathan Hatfield Lecture XXIX*, Am. J. Med. Sc. 210:147 (Aug.) 1945.

ALTEMEIER, W. A.: *Treatment of Acute Hematogenous Osteomyelitis with Penicillin*, Ohio State M. J. 42:489 (May) 1946.



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### DEATH NOTICES ROBERT L. MOBERLY, M.D.

Dr. Robert L. Moberly, 74, Olathe, a member of the Johnson County Medical Society, died May 11. A graduate of the Medico-Chirurgical College of Kansas City, he was licensed in Kansas in 1901 and had practiced here since that time, specializing in otology, laryngology and rhinology.

\* \* \*

### MARION TRUEHEART, M.D.

Dr. Marion Trueheart, 65, president of the Kansas Medical Society from May, 1945 to May, 1946, died suddenly on July 11 after suffering a heart attack. He had practiced in Sterling for 40 years and was founder of the Trueheart clinic there. He received his medical education at the Kansas City Medical College and was graduated in 1904.

Specializing in surgery, Dr. Trueheart was greatly interested in cancer research and treatment and was widely known in that field. Early last spring he was guest speaker at several sessions of the annual meeting of the Mexican Medical Association held in Guadalajara.

Dr. Trueheart was always active in the work of the Kansas Medical Society and at the time of his death was a member of the Committee for the Control of Cancer. National organizations in which he held membership included the American Board of Radiology, American College of Surgeons, American Urological Association, Radiological Society of North America, Inc., American College of Radiology and American Radium Society.

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### ASA M. TOWNSDIN, M.D.

Dr. Asa M. Townsdin, 66, an honorary member of the Cloud County Medical Society, died at his home in Jamestown July 9. He had been in poor health for several years but had continued practicing until his retirement last January.

He was graduated from the Kansas City Medical College in 1903 and began practice at Barnard, where he remained for 17 years before moving to Jamestown. He was active in civic affairs and had served as mayor of both towns in which he practiced.

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### WILLIAM ANDREAS HEAP, M.D.

Dr. William A. Heap, 58, former chief surgeon at the Santa Fe hospital at Mulvane, died July 11 at Canadian, Texas. A graduate of the Chicago Medical School, Dr. Heap had been a surgeon for the Santa Fe for approximately 25 years.

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### OLIVER WATT ELLISON, M.D.

Dr. Oliver W. Ellison, 74, a member of the Montgomery County Medical Society, died July 12 at Independence. He was active in society affairs and had served as president of his county group.

He was graduated from Kansas City Medical College in 1901 and practiced in Sycamore and Elk City until 1915. Since that time he had practiced in Independence.

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### NINIAN B. PRIMM, M.D.

Dr. Ninian B. Prim, 67, who had practiced in the Deerfield community for 42 years, died June 27 after an illness of two weeks. He was a graduate of the College of Physicians and Surgeons at Keokuk, Iowa.

# THE JOURNAL of the KANSAS MEDICAL SOCIETY

*Owned and Published by The Kansas Medical Society*

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Volume XLVII

SEPTEMBER, 1946

Number 9

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## TRAUMATIC INTRACRANIAL HEMORRHAGE FOLLOWING CLOSED HEAD INJURY\*

L. L. Bernstein, M.D. \*\*

Topeka, Kansas

The interest in conditions related to traumatic brain surgery has been greatly stimulated during the past few years because of the frequency of penetrating shell wounds of the skull and brain. Much has been learned, and neuro-surgery has made definite progress in the adequate treatment of cerebral wounds and their complications, which six years ago might have been considered rather unfavorably. In the direct or open brain injury involving destruction along the path of the missile with loss of cerebral substance, the gross pathology has been fairly obvious, and the surgical treatment correspondingly straight forward.

This paper omits, in the main, the problems associated with penetrating wounds of the head, and confines itself to the proposition of intracranial hemorrhage due to closed head injuries only. We are all cognizant of the fact that varying degrees of intracranial hemorrhage are one of the commonest sequelae of head injuries. With the frequency of automotive accidents, injuries of the head assume serious medical as well as surgical importance. Experience has taught that there can be no advocacy of one method of therapy in all injuries to the head accompanied by cerebral trauma. And it is equally true that there can be no hard and fast division of the clinical symptoms or the pathological changes which accompany craniocerebral injuries. Each head injury is an individual problem and may have to be treated by a combination of methods. I shall attempt here a brief review of the various categories usually included in intracranial hemorrhage using the histories of exemplifiable cases which I have had, and presenting only the pertinent facts thereof.

### EXTRADURAL HEMORRHAGE

This type of bleeding occurs from a tear of one of the branches of the middle meningeal vessels; it should be noted, however, that it may also occur from a tear of one of the venous sinuses. There is usually seen a fracture in the vicinity of the squamous portion of the temporal bone crossing over the line of the middle meningeal; but, again, a fracture does not necessarily have to be present. The elastic recoil of the skull, following the trauma, produces an initial separation of the dura from the inner table—this separation will increase as blood is poured out. There may be a lucid interval of one or more hours before symptoms of compression become manifest. There may be a dilatation of the pupil on the homolateral side due to the third nerve becoming stretched on that side. The extradural blood is unable to reach the subarachnoid space so that, usually, there is no blood in the spinal fluid if a tap is done. However, if there has been "contrecoup injury" to the cortex of the opposite cerebral hemisphere, blood will be present in the spinal fluid. This condition, unless promptly treated by surgery, usually proves quickly fatal.

CASE No. 1. J.T., age 23, was found on the 12th of June, 1945, unconscious—presumably knocked down by a vehicle. He remained unconscious for a day and a half, and then was very irrational and showed a weakness of his right arm and leg. He gradually improved, and was admitted to my hospital on the 30th of June—18 days after injury. On examination he was rational and well oriented. The cranial nerves were intact though the fundi showed a slight obscuration of the disc margins. His neurological status was normal and all his reflexes were physiological—except that he showed a very mild residual weakness in his right upper extremity. Plain films of the skull showed a linear fracture in the left temporal region. He remained completely asymp-

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\*\*Neurological Surgeon, Winter General Hospital (Veterans' Administration).

tomatic and was up and around. On the 5th of July, three weeks after his original injury, an oxy-encephalogram was done. To my great surprise he showed a marked displacement of the left lateral ventricle to the right—indicative of an unsuspected, large space occupying intracranial clot; because his spinal fluid was normal the preoperative diagnosis was an extradural hematoma. The following day a left myoplastic craniotomy was done and a large extradural clot was removed. Prior to his discharge less than a month later, an oxy-encephalogram was repeated which showed a return of the displaced left lateral ventricle to its normal position.

Comment: This case shows

1. That one may have a chronic extradural hematoma—though this is not common.
2. The necessity for an air study in any head injury where there is the slightest evidence of residual cortical disturbance.
3. It is possible to have a large intracranial clot without any gross abnormality found in spinal fluid study.
4. The relationship between the site of the fracture line and the grooves for the middle meningeal vessels.

CASE No. 2. P.C., age 22, was in a vehicle accident about midnight the 14th of February, 1945. He was brought in directly to my hospital. He was comatose and, on examination, he had a dilated and fixed pupil on the right, as well as extensor rigidity of his left extremities. X-rays of skull showed a fracture in the right temporal extending horizontally backward. He was immediately operated upon (within five hours of his injury) for an acute extradural hematoma. A large extradural clot was found which extended backwards toward the occipital region. There was no bleeding from the middle meningeal. The right subtemporal craniotomy was enlarged, in order that the source of the bleeding could be adequately searched for posteriorly. The dura over the occipital lobe was depressed five centimeters from the inner table by the tremendous clot—and when the latter was removed, it was very apparent that the gushing blood came from two tears in the lateral sinus. With difficulty, this was eventually controlled with "fibrin foam". The wound was then closed, and his general condition slightly improved for three days, though he never regained consciousness nor was there any change in his right pupil which remained fixed and dilated.

On the fourth postoperative day he very suddenly deteriorated, and because of the possibility of a recurrent right extradural hemorrhage, his operative wound was reopened. There was no extradural clot found, but the dura was surprisingly tense and when this was opened, about forty ccs. of yellow subdural

fluid came away, and in the antero inferior part of the exposed brain, one found a lot of softened and necrotic brain tissue which was evacuated, leaving a large cavity in the temporal lobe. He was left with a large bony decompression and his general condition at the end of the procedure was somewhat more favorable. However, he died two days after his second operation.

Comment:

1. This case presents, then, an example of a massive extradural hematoma resulting from a tearing of the lateral sinus with signs of brain stem compression prior to his initial operation.
2. He showed the localizing value of the dilated pupil; but he showed, too, the grave prognosis which a fixed and dilated pupil portends. When a dilating pupil becomes fixed, it means that the brain stem compression and the resulting intrinsic damage is irreversible.
3. In spite of the apparent tremendous intracranial space which was left after the removal of the clot in the first instance, the brain was tight at the second operation because of acute cerebral oedema which resulted from the severe trauma.
4. He developed an underlying acute subdural hygroma which in this instance was due, probably, to a valvular tear in the arachnoid.
5. He had an explosion of his left temporal lobe which was unrecognized at the first operation.

#### SUBDURAL HEMATOMA

Subdural hemorrhage differs from the extradural type in various ways. It is venous in origin, from a cortical vein—usually of slow development and the initial trauma can be so slight or trivial that it may be forgotten by the patient, until it is unveiled by leading questions in the history. The site of the blow is commonly at the frontal or occipital region and includes such innocuous knocks as bumping the head against a door, or wash basin and so on. The long interval which may be present between the receipt of the minor injury and development of symptoms tends to camouflage the traumatic basis of the condition. The mechanism usually accepted is that a cerebral vein passing from the cortex to a venous sinus is ruptured owing to the brain being suddenly jolted. There is usually no papilloedema and the spinal fluid pressure may be normal though the fluid slightly yellow. On percussion over the head, tenderness may be elicited over the site of the hematoma. The hemorrhage may be diffuse covering the greater part of one hemisphere or it may be localized to one part of the subdural space due to the

rapid clotting of the blood. Thus, it may give rise to definite local signs and symptoms and, in this form, is referred to as a "chronic traumatic subdural hematoma." The blood rarely spreads directly from one hemisphere to the other, unless the injury is at the base of the brain. However, it is important to remember that bilateral subdural hematomata may occur in as high as 25 per cent of all cases, owing to the injury concomitantly produced on the other side of the brain, at the point of contrecoup. Where there is an associated large tear of the arachnoid, as is apt to occur near the basal cisterns, blood will freely escape into the subarachnoid space and thus appear in the cerebro spinal fluid. To enumerate briefly the changes which the clot may undergo—

1. A portion of the blood may be absorbed, the greater part however becoming encysted.
2. The clot becomes softened and liquefied.
3. An envelope is formed around the clot which at first consists of fibrin and later of a very tough fibrinous membrane—the outer membrane being usually very much thinner than the inner or medial membrane related to the hemisphere.
4. The contents alter in color with time as the blood pigment is absorbed, and masses of cholesterol crystals are formed.
5. The cyst wall cannot usually be as readily stripped from the inner surface of the dura as it can be from the brain surface.
6. As the contained red blood cells break down liberating hemoglobin, there is a gradual rise in the osmotic pressure within the cyst—thus the adjacent cerebro spinal fluid of the subarachnoid space is drawn into the cyst. It is also possible for recurrent hemorrhage to occur.
7. So the space occupying mass "grows" which explains the onset of symptoms suggestive of a cerebral tumor—sometimes months or even one or two years after the original injury. Rarely, the hematoma may fibrose or calcify or become infected.

CASE No. 3. J.H., age 37, was in a jeep accident in Holland on the 15th of July, 1945, and sustained a severe closed head injury; he was unconscious for ten hours following which he was markedly confused and disorientated. He had a definite dysphasia but showed no gross motor weakness nor sensory deficit in his extremities. Sixteen days after injury he was admitted to my hospital at which time he was conscious but disorientated and showed a marked mixed aphasia with almost a complete inability to name objects. His other abnormal neurological signs were minimal—slight right central facial weakness, tongue protruded slightly to the right of the midline, slight generalized weakness right upper ex-

tremity. Plain films of the skull showed a linear fracture on the right side in the temporal region. The pineal gland was not visible. Lumbar puncture showed the fluid to be grossly bloody containing 1,860,000 red cells. The preoperative diagnosis here was that of a severe closed head injury with linear fracture of the skull on the right side, and left subdural hematoma with contrecoup lacerations of the left side of the brain in the region of the motor speech area. He was operated on two days after admission (18 days after injury), and a large left parieto temporal flap was made. The exposed dura had the characteristic greenish blue discoloration associated with an underlying hematoma. The dura was turned down in the form of a flap and a fleshy, placenta-like subdural hematoma exposed (Figure 1).



FIGURE 1  
Left side of brain exposed. Brain retractor is elevating a large fleshy subdural hematoma seen at the level of the Sylvian fissure.

There was no inner membrane, but rather extensions of the clot from its deep surface into the cerebral cortex along the Sylvian fissure. Several large cortical vessels, which ran from the brain surface into the clot, were diathermized after silver clips were applied; the clot itself was nibbled away bit by bit. At the end of the intracranial procedure the flap was then replaced and sutured into position (Figure 2). One month later, at which time he was discharged, his neurological status was completely normal, save for a slight hesitancy in naming objects. It is interesting to note that prior to operation he only scored 30% in his test on the dysphasia chart, whereas two weeks after operation he scored 96% correctly—this in spite of the fair amount of actual brain laceration seen in the vicinity of the speech area at the time of operation.

CASE No. 4. C.M., age 24, injured on the continent 14 August, 1945—details unknown. He sustained a severe closed head injury and was unconscious for several hours, thereafter remained drowsy and confused. He was admitted to my hospital on

the 22nd of August, 1945, (9 days after injury) still confused and rather drowsy. Plain films of the skull showed a linear fracture of his left zygomatic arch without displacement; there was no fracture of the skull proper. His neurological examination showed only minimal lateralizing signs, namely slight central weakness of the left side of the face,

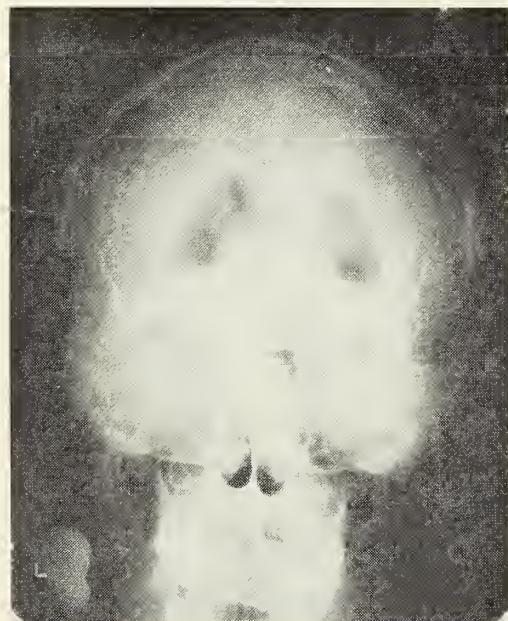


**FIGURE 2**  
Photograph of left lateral x-ray of skull, post-operatively. This shows the osteoplastic flap with the decompression of its base. Silver clips are seen which were applied to cortical vessels, mainly in the region of the Sylvian fissure, that were feeding the sub-dural hematoma.

and a slight weakness of his left upper extremity with diminished abdominals on the left side; his plantar responses were bilaterally extensor. His lumbar puncture pressure was 350 but the cells were normal and the total protein was not elevated. Recheck of his skull films showed a pineal shadow in

lateral projections only; this shadow was not visible in the AP view. On the basis of his lateralizing signs, we suspected a subdural hematoma on the right side. On the third day after his admission, he had a bout of vomiting and his blood pressure began to rise. Operation was prepared for and then a small oxy-encephalogram was done giving the patient at the same time hypertonic glucose intravenously; he tolerated this procedure very well.

The encephalogram (Figure 3) showed both ventricles to be on the large side of normal, the left one larger than the right in the anterior and mid portion, but smaller than the right in the posterior part. There was a slight shift of the third ventricle to the right and the most interesting finding in this air study was the shadow of the epipineal recess which showed a shift to the right of one-half inch. This finding of homolateral signs, due to a large space occupying lesion above the tentorium, is certainly uncommon and is explained by the shift of the brain stem as well as the hemisphere, in this instance, towards the right with *compression of the right cerebral peduncle* against the free edge of the tentorium. He was operated on forthwith, and a left fronto-parieto-temporal osteoplastic flap made; a large, diffuse, fluid subdural hematoma was removed. There was no definitely formed inner or outer membrane, though there were some small shaggy organized clots on the inner surface of the dura. The dura in this instance was left open in anticipation of postoperative edema and a small subtemporal decompression was done prior to replacing the bone flap. A burr hole was then made on the right side to rule out a bilateral subdural. Because of the mid-brain compression preoperatively, his convalescence was ex-



**FIGURE 3**  
Photograph of PA and left lateral of skull, following encephalography, which shows the slight shift of the 3rd ventricle to the right and also the shadow of the epipineal recess which is displaced to the right.



pected to be rather stormy for the first few days—and so it was. He was put on luminal following two convulsive seizures which he had in the first 24 hours; these did not recur.

His left sided weakness improved and he became asymptomatic. A repeat air study done prior to his discharge about 4 weeks later showed the epipineal recess and ventricular system to be in normal position. There was a suggestive residual atrophy of the left hemisphere.

**Comment:**

1. This case indicates an example where the clinical neurological signs might have misled one to plan the operation "on the wrong side"; it certainly is rare to have homolateral signs on the basis of a large supratentorial space occupying mass.
2. Where the pineal shadow is not visible in the AP view, one may be fortunate with the air study to visualize the epipineal recess—the latter normally is in the midline and if displaced has the same significance as a displaced pineal shadow.
3. In spite of the large fluid subdural hematoma without well formed membrane, the cytology and chemistry of the lumbar spinal fluid was normal.

CASE No. 5. J.R., age 36, was injured on the 26th of May, 1945, in a vehicle accident. He sustained lacerations in his right parietal scalp, bleed-

ing from his left ear and he was immediately unconscious. He was kept in another hospital for five days and then, when they noted that his coma was increasing, they did a lumbar puncture which showed a pressure of 300 and the fluid heavily blood stained. He was transferred immediately then to my hospital—at which time he was unconscious and responded only to very painful stimuli; he had bilateral papilloedema; he had a left peripheral facial palsy and his plantar response was equivocal on the left and flexor on the right. His X-ray showed a linear fracture of the left occipito-masto-temporal region. He had no visible pineal but he did have something which helped us more definitely in the localizing diagnosis—calcification in the glomus of both choroid plexuses with displacement of the left one towards the right (Figure 4).

He was immediately operated upon for an acute left subdural hematoma; there was an associated laceration of the brain in the temporo-parietal lobe—and this necrotic brain tissue was carefully removed. The dura was closed. The patient had an uninterrupted convalescence and showed no residual neurological signs apart from his left peripheral facial palsy. Air study done prior to his discharge showed moderate symmetrical dilatation of his ventricular system. Films showed return of the displaced left glomus to its normal position. (Figures 5 and 6).

**Comment:**

1. Emphasizes the need for cases who are un-



FIGURE 4  
Figure 4 shows the displacement of the left choroid plexus upwards and medially.



FIGURE 5  
Post-operative film to show the return of left choroid plexus to its normal position.

conscious following head injury to be *immediately* thoroughly assessed from the neurological point of view and to be very carefully observed from then on with adequate supervision.

2. In any case where papilloedema is already evident, it is most dangerous to do a lumbar puncture; it is uncommon to find papilloedema within a few days after a closed head injury.
3. The value of adequate stereoscopic skull films is evident in this case—calcification of the glomus is uncommon—present in about eight per cent of cases.
4. It is felt that an air study following operation in closed head injury is of value because it shows the degree of an atrophic process which may occur—it also consoles the surgeon to be certain that the displaced ventricular system has resumed its normal position.

CASE No. 6. J.M., age 25, was admitted to the neuropsychiatric service of my hospital because of increasing headaches and recent weakness of the left arm and leg. Examination showed him to be drowsy with almost a complete left hemiplegia without any visual field defect. He showed signs of increased intracranial pressure—spinal fluid pressure 550, the fluid being clear and colorless and containing one lymphocyte; he had bilateral papilloedema. X-ray showed a small linear fracture in the right frontal region and a small foreign body, presumably gravel, in the right frontal scalp. These two findings sug-

gested definitely trauma as the cause, and armed with this knowledge, the patient was requestioned. He eventually remembered having been thrown from a jeep, two months before the onset of his present illness; he remembered striking his head lightly and was only slightly dazed and therefore thought this injury to be of no consequence. These facts altogether seemed to point to a subdural hematoma, on his right side, as the most likely diagnosis. Consequently, a burr hole was made in his right parietal region, and when the dura was opened we were greatly surprised to get about 35 ccs. of thick greenish pus. The operation was completed by doing an extensive craniectomy with a complete evacuation of pus from this subdural empyema. Penicillin was instilled locally and the dura and scalp were tightly closed. The origin of this subdural abscess is obscure, but one might speculate that he had first a subdural hematoma as a result of his apparently mild injury, and this subsequently became infected through the linear fracture. His profound hemiplegia improved sufficiently to allow him to be a walking patient; subsequent air study prior to his discharge from hospital showed no evidence of any space occupying lesion, but only mild dilatation of his right lateral ventricle.

#### SUBDURAL HYGROMA

Subdural hygroma is a collection of spinal fluid in the potential subdural space. These localized pools of fluid may be large enough to produce compression signs. There are several theories on its mechanism of formation. It is thought that following an injury where the arachnoid is torn, the cerebro spinal

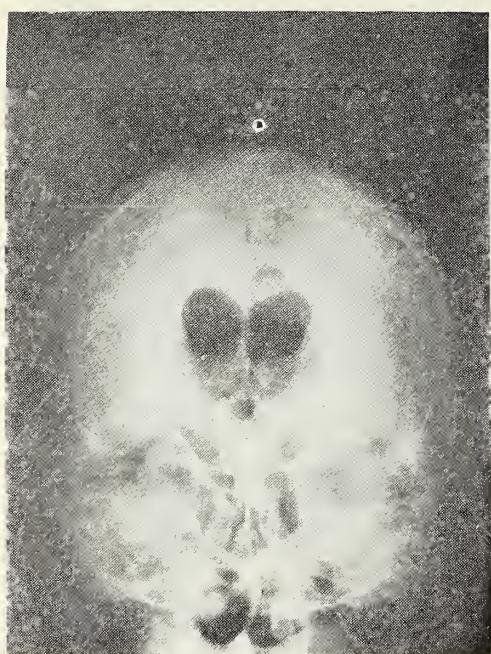


FIGURE 6

Air study done one month following operation; AP and rt lateral stereos show moderate symmetrical dilatation of the lateral ventricular system and 3rd ventricle. Figure 6b shows as well the craniotomy.

fluid is allowed to escape from the subarachnoid space into the subdural space and the tear in the arachnoid acts as a one-way valve which allows fluid into this potential space but not out of it. Another theory is that the injury to the lining cells of the subdural space results in a transudation of fluid into that potential area. The fact that the protein content of the fluid, in the subdural hygroma, is frequently higher than that of the normal cerebro spinal fluid may support the theory of its formation. A third possibility is that the subdural hygroma represents the end results in the phases of change in what was originally a subdural hematoma.

CASE No. 7. A.E., age 33, received a closed head injury in Germany early in 1945 and was found lying in a field. He was brought into my hospital in the middle of May and he was a cadaverous, emaciated looking individual weighing only about 80 pounds, though he was 5 feet, 10 inches in height. On examination he showed a complete right hemiplegia and complete aphasia, with all the classical neurological signs. Lumbar puncture showed no elevation of pressure but I felt that because of his emaciated, dehydrated state, pressure reading was not significant.

X-ray of skull showed a linear fracture in the left parieto temporal region; pineal gland was not visible. The preoperative diagnosis was possible left subdural hematoma. A left subtemporal craniotomy was done, and when the dura was carefully opened, 50 or 60 ccs. of golden yellow fluid escaped, beneath which was seen a fine membrane adherent to the surface of the arachnoid. Following the operation he began to speak and move his right limbs—within five days. With forced feeding his weight increased and prior to discharge a month later he was able to walk around the ward with assistance. I had a letter from him at Christmas time and he was in South Africa, which is his home, working in the office of one of the oil companies there.

#### SUBARACHNOID HEMORRHAGE

The spontaneous type of subarachnoid hemorrhage is usually due to a rupture of a small berry aneurysm on the circle of Willis or middle cerebral artery. Time will not permit any discussion of this problem—but I would like to emphasize that the idea that this domain is distant from the therapeutic realm of surgery belongs to the past.

The traumatic type of subarachnoid hemorrhage, by itself, is usually not a surgical problem unless associated with damage to other parts of the cranial contents. When the hemorrhage is into large cisterns at the base of the brain, death may quickly result from pressure on the medulla. Over the cortex, where the subarachnoid space is subdivided by numerous trabeculae, the blood will infiltrate this net-

work and usually a large and massive clot will not be formed. The spinal fluid will show varying amounts of blood, and after four hours the fluid may be xanthochromic. The latter increases in intensity during the first week and usually fades within three weeks.

#### INTRACEREBRAL HEMORRHAGE

1. Spontaneous rupture of an artery in the interior of the brain, at present, is a condition of interest mainly to the physician rather than to the surgeon, though this may not remain so in the future.

2. Traumatic intracerebral hemorrhage falls into two large groups.

- A. There may be numerous small punctate hemorrhages scattered throughout the entire brain—very often seen in cases even where the skull is not fractured. The mechanism of production may be explained by a sudden wave of cerebro-spinal fluid from the subarachnoid space, into the perivascular extension of that space, into the brain, producing a stretching of these fibrillary extensions from the vessel walls, which in turn injures the delicate wall at the point of stretching and tearing.

CASE No. 8. W.W., age 29, was injured in a jeep accident, and sustained a very severe closed head injury. He was admitted to the hospital one hour after injury. He was comatose, had inactive pupils—the right one was larger than the left and was fixed; he had spastic limbs with reflex mass exten-sion, on stimulation. His temperature was 106 degrees F. It was concluded that there had been very severe bilateral cerebral contusion with no lateralizing sign but signs of brain stem involvement. X-ray of skull showed no fracture. He was given all supportive measures, but deteriorated rapidly and expired five and a half hours after admission. At autopsy, he had no demonstrable fracture of the skull or involvement of any other organ except the brain. (Figure 7).

B. One may have a large localized intracerebral hemorrhage resulting from laceration of the brain. The hemorrhage originates from the cortical surface and then extends for some distance into the depths of the brain—even into the ventricle.

A more uncommon occurrence is the onset of symptoms of cerebral hemorrhage some days after the receipt of an injury to the head. This is explained by focus of cerebral softening due to the trauma implicating an adjacent vessel which later ruptures resulting in a secondary hemorrhage.

CASE No. 9. J.P., age 30, had a tangential shrapnel wound of the left side of the head resulting in a compound depressed fracture in the left mid-parietal region. He was operated on the next day at a mobile

neurosurgical unit with complete debridement of the scalp wound and removal of the depressed fractured bone. The dura was completely intact and though he had a right hemiplegia and dysphasia, there was no evidence on looking at the exposed dura that lacerated brain was beneath it; and, therefore, the dura was not opened. He was admitted to my hospital six days later at which time he was semiconscious and still showed a right hemiplegia. The

spinal fluid pressure was only a little higher than normal but the cytology and chemistry were normal. He was considered a possible candidate for a left subdural hematoma or diffuse left sided cerebral contusion or left intracerebral hemorrhage. He was treated conservatively, watched carefully under the standardized neurosurgical regime, and five days after his admission it was noted that he was a little drowsy and for the first time his left pupil was larger than the right and reacted only sluggishly. He was operated upon immediately, and a large left fronto-parietal flap turned down. The dura was quite tense and this was opened widely. Directly beneath the site of the original depressed fracture, there was seen projecting through the surface of the brain, the superficial part of an intracerebral clot. The whole intracerebral clot and fluid component thereof was evacuated—this was very extensive and, when removed, the brain sagged like a deflated bag. The flap was replaced, and at the end of the operation it was gratifying to note that both pupils were of normal size, equal, and reacted actively to light. He had an uneventful postoperative course and, prior to his discharge one month later, his right hemiplegia improved sufficiently for him to walk around the hospital, and his aphasia improved to the degree that he could converse with his friends—though very slowly.

CASE No. 10. J.M., age 23, was injured on the 27th of February, 1945, sustaining a compound depressed fracture in the right frontal area with only slight dural penetration and minimal local brain injury. He was operated on next day at the mobile neurosurgical unit where complete debridement of the wound was done, depressed fracture removed, the small amount of damaged brain tissue removed, and the dura closed. He was admitted to my hospital on the 1st day of March, 1945, at which time the neurological status was entirely normal except for a central right facial weakness. About five weeks after his admission, while he was awaiting his return to Canada, he complained suddenly of severe headache and then vomited. Within the next hour he had a focal seizure starting at the left angle of the mouth, with posturing of the extremities, suggestive of decerebrate rigidity. He had an apparent left hemiparesis. Lumbar puncture showed a pressure of 410, the fluid appearing grossly blood stained. The preoperative diagnosis was a right intracerebral hemorrhage. The original wound was excised and a large osteoplastic flap turned down. The dura was extremely tight and bulging and it was widely opened. The brain, at the site of the first operation, appeared necrotic and at this defect in the cortex one saw a clot. This was enucleated with the finger, and it was found that the clot extended anteriorly



FIGURE 7

Figure 7a and 7b coronal sections of the brain showing numerous areas of intra-cortical and intra-cerebral hemorrhage. 7c—section through pons and through occipital lobe similarly show areas of hemorrhage.

into the frontal pole as well as posteriorly. When this was removed, the clot was still seen to extend inferiorly and, as this was carefully teased out of its bed, one then found that it came out of the anterior horn of the right lateral ventricle, the floor of which was well visualized and from the floor there was an active bleeder. This was dealt with by a small piece of fibrin foam. He had a stormy postoperative course, because of the local edema related to the ventricular floor, but he improved slowly and prior to his dis-

charge six weeks later was up and walking around the ward.

In concluding, I wish to emphasize that this presentation has been no more than an abbreviated survey of a few of the many problems involved in the management and treatment of the various types of intracranial hemorrhage, with case histories which were intended to suggest, as well as to demonstrate, ideas and precepts in accord with the present trend of thought in neurological surgery.

## POLIOMYELITIS

### CLINICAL AND EPIDEMIOLOGICAL CONSIDERATIONS

Herbert A. Wenner, M.D.\*

Kansas City, Kansas

Poliomyelitis is an acute infectious disease caused by a filterable virus. The symptomatology of the disease varies, but in its characteristic form it produces in man flaccid paralysis involving few or many muscle groups. The manner of transmission of the virus to humans is not understood with certainty. Some believe the disease to be transmitted from person to person; others consider that the natural epidemiological cycle is dependent on environmental influences, inasmuch as the disease has the highest incidence in epidemics which occur invariably in summer and autumn months.

#### CHARACTERISTICS OF THE VIRUS

The virus of poliomyelitis is exceedingly small; it is among the smallest of the filterable infectious agents. The virus withstands weak solutions of phenol. It is destroyed by oxidizing agents such as hydrogen peroxide and potassium permanganate. Chlorination of drinking water in the concentration generally used will not inactivate all of the virus, although a great deal is destroyed.

The presence of poliomyelitis virus can be detected only by inoculation of favorable material into monkeys or chimpanzees. Rarely strains may be adapted to inbred strains of white mice. The virus causes flaccid paralysis in a number of species of monkeys and typical lesions appear in the spinal cords of these animals. In chimpanzees infection arising from poliomyelitis virus may be exceedingly mild, simulating in some respects attacks of abortive poliomyelitis in man. In mice encephalitis or myelitis occurs. Recently a rodent strain of poliomyelitis virus has been cultivated in the developing chick embryo.

#### CLINICAL ASPECTS

Poliomyelitis is a disease which affects children and young adults more frequently than infants and adults over 25 years of age. The disease is readily diagnosed with the onset of flaccid paralysis involving one or more of the extremities. An increase in local prevalence of paralyzed cases during summer months brings the disease to the fore, and mild and abortive attacks are recognized. It is not improbable that abortive attacks of poliomyelitis occur in most communities each summer, but because of the quick and uneventful recovery these are seldom if ever recognized as poliomyelitis.

During epidemics frank paralytic cases appear. It is estimated that these cases represent about 10 per cent of all that are infected; the remaining 90 per cent have mild and uneventful illnesses. The paralyzed cases, by and large, fall into two groups—the spinal and the bulbar types. The relative ratio of spinal and bulbar forms of poliomyelitis varies somewhat with age; a larger proportion of individuals over 10 years of age have bulbar paralysis. There is undoubtedly an encephalitic phase to this disease, but in my experience it is not seen frequently.

The onset of poliomyelitis precedes the appearance of paralysis by four to ten days. Usually, there is an initial period of fever (101-104° F.) lasting two or four days with symptoms of sore throat, headache, malaise and abdominal pain. The patient feels better for a period of two to six days. Following this the fever rises, the neck is stiff and paralysis may or may not intervene. Usually at this stage paralysis occurs. A number of individuals have the initial symptoms and are well thereafter. These illnesses are hard to classify. In a small group of patients the onset may be quite sudden. The severity of the criti-

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cal symptoms bears no relationship to the subsequent course of the disease.

The general distribution of paralyzed parts has been noted by many in different outbreaks of poliomyelitis. The arms and legs are most often affected. The palsies are of all grades of severity varying from transient weakness to complete and permanent paralysis. There is an election of certain muscle groups for paralysis. In the leg the quadriceps femoris, the peroneals, the flexors of the foot and extensors of the toes are commonly involved. In the arm the proximal muscle groups are affected more than distal groups. The deltoid is often permanently paralyzed. Muscles are usually affected in groups corresponding roughly to myotomes or muscles supplied by certain segments of the cord. If a muscle is paralyzed, other muscles which derive their innervation from the same segment are involved to some extent.

In fatal cases death usually results from paralysis of the muscles of respiration. The diaphragm is paralyzed infrequently. Respiratory failure results if the intercostal muscles are affected in addition to the diaphragm. Lesions in the lower cervical and upper thoracic segments of the spinal cord affect these muscles of respiration. In the bulbar form of the disease motor muscles and their peripheral ganglia are attacked. The VIIth nerve is attacked most commonly. The VIth, Xth, XIth and XIIth nerves are affected also, but less often than the VIIth.

#### DIAGNOSIS

Paralytic cases only can be diagnosed with assurance. This is a disadvantage because the majority of the people infected with the virus are never known. Simple methods to detect those individuals who have the virus in their bodies or who have developed immunity to the virus are not available.

In the differential diagnosis encephalitis of virus origin, namely equine encephalitis and St. Louis encephalitis, may be confusing particularly in abortive forms of these illnesses. Occasionally lymphocytic choriomeningitis, mumps encephalitis, and Landry's form of ascending paralysis may prove confusing. Complement-fixation tests using acute and convalescent serums assist in differentiating some of these diseases from poliomyelitis.

The laboratory findings may be of help. The circulating leukocytes seldom rise above 15,000 cells per cu. mm. of blood. A pleocytosis may occur; the cell count usually ranges between 20 and 200 cells per cu. mm. of spinal fluid. Some paralyzed cases may not show an increase in the spinal fluid cell count at the beginning of paralysis; abortive cases may have a marked increase. The highest cell count I have seen has been 1200 cells. There is no relation-

ship between the cell count and the severity of the disease.

#### PATHOGENESIS

Man is the only known species to spontaneously carry poliomyelitis virus and to acquire illness as a result of infection with this virus. Flexner and his associates adduced evidence to indicate that the virus entered the central nervous system through mucous membrane of the naso-pharynx. Subsequently it was shown that the virus spreads along neuronal pathways in the brain stem and in the spinal cord. Evidence was brought forward to indicate that virus spread along the axis cylinders of neurons in monkeys.

It is more difficult to follow the pathways used by the virus in entering the central nervous system of man. The main reason for this is the widespread dissemination of virus in fatal cases of poliomyelitis. The point of entrance cannot be recognized because of the diffuse and intense cellular reaction appearing as a result of infection.

In the primary spinal type of poliomyelitis lesions are concentrated in the spinal cord. It has been suggested that poliomyelitis virus is implanted on naked neurons in the intestinal wall and that visceral afferent fibers from the intestine by way of dorsal root ganglions provide the easiest pathway for invasion of the central nervous system. Evidence in support of the intestinal entry in man is impressive but not conclusive.

There is evidence that the level of the central nervous system attacked by the virus is determined by neuronal connections in peripheral tissue where virus is implanted. The site of implantation may be the oropharynx, skin, gut, or nasopharynx. Subsequent spread within the nervous system depends upon facilities of neuronal pathways which in their own right are more or less resistant to its transfer. In fatal bulbar types of poliomyelitis the intensity of lesions in the medulla suggests that virus enters this region by way of the cranial nerves.

#### DETECTION OF VIRUS IN PATIENTS AND CONTACTS

Poliomyelitis virus can be detected in oropharyngeal exudate and in feces of individuals sick with the disease. Early epidemiological studies indicated that the disease is spread by direct contact. Virus has been detected in the nasopharynx of contacts, and once virus was detected five days before "symptoms" of poliomyelitis appeared. The detection of virus in the nasopharynx was not easily accomplished. With the use of a different method oropharyngeal exudates obtained from frank cases yielded a significantly higher number of positive tests. It seems fairly clear that the amount of virus in the oropharynx, at least, diminishes during the first fortnight of illness, so that

it is no longer detectable within 4 to 7 days after the onset of paralysis. It is equally clear that virus is present in the oropharynx during the first phase (pre-paralytic) of illness. Its presence there in an ambulatory patient during a critical period when virus is rapidly multiplying in the tissues of the host cannot be without epidemiological significance. However, evidence of contact spread is circumstantial.

Virus has been readily detected in colonic contents and feces of infected persons and in apparently healthy contacts. There is a lot of virus in stools and it is readily detected. The fact has been used to provide a tool for studies on (1) the relative incidence of abortive forms of the disease in any community, (2) the duration of the carrier state, and (3) the deposition of virus in sewage in epidemic and endemic periods.

Persons living in the environment of a frank or abortive case of poliomyelitis may carry virus in their stools. Many of these carriers do not become obviously ill, although they are parasitized by this pathogenic and infectious agent. However, if virus is sought out in other apparently healthy households of the same community, only a few carriers can be detected. The stool carrier rate appears to be related directly to frank cases of the disease.

The duration of the carrier state varies. The persistence of poliomyelitis virus in the pharynx is of brief duration (see above). The virus has been detected in feces of patients before the onset of paralysis. It may be excreted in feces for as long as 128 days. Just as in the pharynx, there is a continuous decrement in the amount of virus excreted from the intestinal contents in the course of the disease. During the first week or so 75 to 90 per cent of all individuals have detectable amounts of virus. By the 7th and 8th weeks virus can be detected in only 12 per cent. It would appear that there are no persistent carriers of virus.

#### PRESENCE OF VIRUS IN MAN'S ENVIRONMENT

The presence of poliomyelitis virus in feces indicated that it was present in sewage. Subsequent tests confirmed this hypothesis. In 1941 poliomyelitis virus was detected in or on flies trapped in the vicinity of human cases. In most instances flies had direct access to human feces. These findings provided the first evidence that poliomyelitis virus can be carried about *in nature* by a living organism other than man.

Food has been exposed to flies in unscreened and rather primitive homes in which there were paralyzed children. This food on being fed to chimpanzees contained enough virus to infect these animals. These results deserve additional study. They implicate the fly (green bottle-neck fly particularly) in

the natural epidemiological cycle of poliomyelitis. This evidence also brings forward the idea that ingestion of virus may be more important than has heretofore been recognized.

It is difficult to state what these findings mean in respect to the epidemiology of poliomyelitis. It is an easy statement to say that all poliomyelitis is due to direct contact. Peculiarities in the over-all epidemiological pattern, namely its characteristic summer prevalence, the changing age incidence, its habit of attacking a few people in one community and then skipping to another far distant from the first has challenged the epidemiologist for an answer. Thus far, a satisfactory answer is still to be arrived at. The unraveling of this epidemiological snarl would be hastened if simpler, inexpensive and less time-consuming methods were available.

#### PROGNOSIS

It is difficult to give a definite prognosis in poliomyelitis. Age has some influence. The younger the child the more likely it is that function will be restored. Bulbar cases are less hopeful. The outlook is virtually hopeless with paralysis of the diaphragm and intercostals. The mortality rate varies in different epidemics and in various places. In 1916 the over-all mortality rate was about 20 per cent; in recent years it is about three to ten per cent. The mortality rate increases with age. Reduction in mortality rate in recent years is in part due to inclusion of abortive cases in the reported incidences of this disease.

In a like manner it is impossible at the onset to say what the extent or degree of paralysis will be.

#### PREVENTION

There is no satisfactory means of prevention. A reliable vaccine is not available at the present time. The use of convalescent serum or gamma globulin as a preventive measure in exposed individuals may be tried, but any real benefit is difficult to realize because low attack rates occur, and the chances of not developing paralytic poliomyelitis are at least nine to one. This statement is not made to discredit the use of a proved and safe antigen. It is made to point out that apparently good results following the use of serum may be merely nature's kindness to the physician.

#### TREATMENT

The diagnosis and treatment of paralytic poliomyelitis is a divided responsibility. The division of labor, however unequal, falls upon the internist or pediatrician, orthopedic surgeon, and the physical therapist. The internist examines the patient, checks the diagnosis, carries out routine studies, and guides the metabolic needs of the individual during the acute phase of the illness. The orthopedic surgeon

sees the patient on admission, and directs the care of the patient in association with the director of physical medicine in the acute and early convalescent periods of the disease. Their work is clearly defined when it is possible for them to see the degree of residual and often permanent paralysis of various muscle groups in order that they can anticipate resulting structural deformities. Some of this requires physical therapy; later, surgical procedures may be required. In the acute and chronic phase of poliomyelitis a very large amount of work falls to the physical therapist. The need of modified Kenny type of treatment in poliomyelitis is well realized. It is time consuming, and requires intelligent care. I shall not extend myself to discuss the treatment. Doctor Martin has, in the following paper, discussed the principles and practice of present treatment in the early and late stages of poliomyelitis.

Supportive treatment is not often urgent, except in bulbar types of poliomyelitis. Adequate fluid balance and efforts at securing the comfort of the patient are the necessary prerequisites of care in the

acute phase of illness. The respirator should be used with onset of weakness or paralysis of the respiratory muscles, but only when respiration becomes labored to the point of exhaustion or if there is oxygen deficit. Oxygen is useful in these cases.

The use of convalescent serum in the treatment of poliomyelitis is not of proved value. Experimental observations support this. It is quite clear that at the time when serum is used the virus has established its intracellular habitat, is widely disseminated, and the damage is done. Serum will not correct or prevent this.

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## TREATMENT OF POLIOMYELITIS

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Acute poliomyelitis is an infectious disease with preliminary systemic manifestations which are followed in a small percentage of cases by inflammatory changes in the central nervous system. The involvement of the central nervous system by the virus of poliomyelitis results in a condition that is characterized clinically by hyperirritability and persistent shortening of certain muscle groups and weakness and paralysis in the same or other muscle groups. This spasm or shortening, as well as the weakness, may be responsible for many of the deformities and crippling after-effects of the disease.

The principle of treatment in the early stages of the disease is to relieve the pain, release the spasm as quickly as possible, and by detailed muscle re-education make maximum use of all remaining neuromuscular units not destroyed by the initial invasion of the virus. In the later stages every available means is taken to rehabilitate the patient to his maximum functional capacity. This may include use of special apparatus and braces, various surgical procedures and often physical therapy over a prolonged period.

The first step in the treatment of the acutely ill is to save the patient's life. This depends on care-

ful medical and nursing care primarily for those with bulbar involvement and involvement of the respiratory muscles. The transportation of these patients to the hospital is essential and must be done with the greatest care. The child who can not cough or swallow is likely to literally drown in his own secretions. Therefore, for transportation the patient should be placed on the stretcher on his abdomen and with his head lower than the rest of the body. The ambulance should be warm and the drive should be as short, slow and smooth as possible. Pain and spasm is definitely aggravated by the jolting and swaying of a rough, fast nerve-racking drive.

Generally an acutely ill patient should be taken to a hospital near his home. If a respirator is needed and is not available locally, it is best to have a respirator moved to the hospital. The patient should be placed in a room maintained at about 80°F and the temperature maintained at a fairly constant level throughout the 24 hours. It has been shown by allowing the room to cool at night muscle pain and spasm is aggravated. Preliminary examinations should be as brief as possible so as not to tire the patient or aggravate pain and spasm. In most cases a spinal puncture is indicated to confirm the diagnosis and to give an indication of whether or not the disease has as yet reached its peak as far as central nervous

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system involvement is concerned. The patient may be isolated for a period of three weeks.

In order to obtain the desired careful medical and nursing care it is important that the physician carefully prescribe the routine desired. The patient should be handled as little as possible; whenever he is handled or moved the attendant's hands should be warm, bed pans or urinals should be warm, and in moving the patient support should be given to the joints and no pressure applied over the tender muscles. The patient's position should be changed several times daily and part of the time he should be placed in a prone position, unless there is spasm of the diaphragm. It is not necessary to give baths during the period of painful spasm but when they are given the patient should be dried without vigorous rubbing. No alcohol rubs or massages should be given during the acute stages. The majority of these patients have considerable distention and it is advisable to order a soapsuds enema during the first 24 hours which may need to be repeated every second day.

The position of the patient in bed should be arranged to keep him as comfortable as possible, as well as to maintain normal body alignment and to prevent the assumption of positions that would favor the development of later deformities. The normal body alignment is best maintained by equipping the bed with a fracture board and placing a foot board four inches below the foot of the mattress. As soon as possible the patient should be instructed to keep his feet flat against the foot board. The patient who has considerable spasm and pain in the hip flexors and hamstring muscles may be made more comfortable by placing a pillow lengthwise under the calves of the legs. This will maintain the thighs and hips in a moderately flexed position. The knees should always point toward the ceiling and supports may be necessary to prevent the legs from assuming a position of external rotation. In the prone lying position the patient's feet should project below the foot of the mattress. A fold of towels may be placed under the ankles to slightly flex the knees. Also pads made of folded bath towels should be placed under the shoulders to maintain the normal position of the scapula. As soon as the patient tolerates moving he should be turned to the prone position four to six times daily. During the febrile stage the patient should be given plenty of fluids. The diet should be light and well balanced and if the patient is unable to swallow, nourishment may be maintained by use of the stomach tube or intravenous feedings. Occasionally catheterization is necessary for retention of urine. If the patient has any difficulty in breathing, swallowing, talking or coughing an aspirator should be kept at the patient's bedside and a respirator should be available.

Respiratory difficulty due to spasm and muscular weakness manifests itself by rapid, shallow breathing, cyanosis, rigid flat chest, inability to take a deep breath, a position of inward rotation of the adducted arms, use of the neck muscles in an attempt to elevate the rib cage and depression of the intercostal spaces. Usually the application of hot packs to the chest wall every few minutes will result in improvement of respiration in those cases where there is marked amount of spasm and tightness. If the patient has spasm in the diaphragm he will have difficulty in expiration. The chest will be expanded, the eye balls will be prominent and the abdomen will be raised during exhalation. Hot packs applied around the body over the lower chest and abdomen every few minutes, in the majority of cases, will relieve much of the spasm. These patients should be kept on their backs and have the head of the bed elevated. If the respiratory difficulty is due to bulbar paralysis, there will be shallow irregular breathing with difficulty talking and swallowing. These patients should be in a prone position with the bed in the head down position.

Not all of the patients who have respiratory difficulty can be helped by a respirator, in fact, in some instances the use of the respirator may be definitely harmful. The respirator is most consistently helpful in the cases that have actual paralysis of the primary respiratory muscles, including the intercostals and the diaphragm, due to damage of the anterior horn cells of the spinal cord. The respirator may occasionally be of aid in those patients whose difficulty in breathing is due to a disturbance of the nerve centers in the medulla. The respirator is rarely of any value and sometimes definitely harmful in those who have a severe bulbar lesion with collections of mucus in and around the glottis and paralysis of the pharynx.

The respirator should be considered more than a device for emergency life saving. It is a device which will provide physiologic rest for the muscles of respiration. The tender partially paralyzed muscles of respiration should have rest and avoidance of fatigue just as much as involved muscles in the extremities. In most cases where respiratory involvement is apparent, the patient should be placed in the respirator before cyanosis develops. In general, for the patients with respiratory muscle involvement who are given periods of rest in the respirator, its use should be continued until the patient's temperature is normal and all muscle soreness and tenderness has disappeared. In some cases it is necessary to continue intermittently to use the respirator for several weeks or months. The purpose of the respirator, of course, is to bring about the passage of air in and

out of the patient's lungs for indefinite periods without harm to the patient or the lung tissue. There must at all times be a freely open airway to permit satisfactory use of the respirator. The rate of respiration should be between 15 and 20 for adults and 20 to 30 per minute for children. The cooperation of the patient is very helpful in successfully using the respirator. He should learn to completely relax or synchronize his breathing with that of the cycle of the respirator. The usual negative pressure used in the respirator is 14 to 18 cm. of water. Usually no positive pressure is required and expiration depends upon the elastic recoil of the thoracic cage of the thorax in response to the negative pressure of the respirator.

Constant nursing care should be continued while the patient is in the respirator. Hot packs may be applied for muscles in spasm and prevention of deformities should be considered, especially in those patients that require a long period of care in the respirator. It is well to remember that many patients whose respiratory paralysis has been adequately treated in the respirator have died from conditions resulting from poor nursing and medical care. Position must be changed frequently as the danger of pneumonia is considerable. Proper alignment of the body must be maintained to prevent the tendency to deformity. Postural drainage may be necessary and care of the skin is of great importance. Adequate fluid to keep the mucus from becoming thick and tenacious is important.

The relief of pain and muscle spasm is of paramount importance in the treatment of early poliomyelitis. The simple procedures of properly supporting the patient in a warm bed and in properly relaxed position will do much to relieve pain and provide relaxation of spasm. Mild sedatives may be used while the fever is still elevated. Codeine in small doses is probably most effective. As the patient's temperature begins to approach normal or even earlier in some cases, the use of hot packs will relieve much of the pain and muscle spasm. In children who are old enough to cooperate the simple expedient of using the prone or lay-on packs is usually adequate. In the child under 4 or 5 years old it is usually necessary to use the pin-on packs as described by Kenny and her co-workers. The packs are cut from a soft old wool to fit on the muscular areas. The packs are applied in such a way as not to inhibit motion at the joints. The hot moist packs are rapidly dried as much as possible and then applied at a temperature as hot as the patient can tolerate. The packs are covered by water-proof material and then surrounded by a dry wool pack to maintain the heat as long as possible. These packs usually cool off in about 15 minutes. Knapp has

pointed out that the intensive heat at the beginning followed by the gradual cooling off period results in a more marked relief of pain than will result from using only comfortably warm packs that are maintained at a constant temperature. The general procedure is to apply the packs from two to six hours daily, depending first on the severity of pain and spasm, second, the general condition of the patient and third the amount of relief and relaxation that is obtained with the packs. It is well to remember that in most instances volunteer nurses aids or ward helpers can be trained to carry out packing procedures in a satisfactory manner. Many children without extensive involvement can be cared for at home by carefully instructed intelligent parents.

The use of drugs, notably neostigmine and curare, has been tried with some success for the relief of pain and spasm. The marked depressant effect of curare on all muscles should make inexperienced persons wary of its use in acutely ill patients who may be showing muscular weakness.

Very early in the course of disease passive exercise to the point short of discomfort is started. This is usually carried out twice daily. If the patient can move actively without increasing his pain or spasm and without incoordination, he is encouraged to move himself from time to time in his bed. As voluntary function returns to the weakened or paralyzed muscles, the patient is carefully instructed by the physical therapist in the proper use of each individual muscle unit or group. The purpose of the early detailed and intensive muscle reeducation procedure is to make it possible for the patient to obtain the maximum co-ordinated use of all functioning neuromuscular units. Mild stretching may be necessary on tight shortened muscles.

At the end of the three weeks isolation period most of the patients will have only a moderate amount of residual pain and spasm in the muscles. They are then started on hydrotherapy and are treated in a warm bath with a water temperature maintained at 100 to 104° F. for periods of from 10 to 20 minutes daily. The use of the warm bath usually further relieves muscular soreness and tightness. Also the patient is helped and encouraged to actively use his weakened muscles. The effect on the morale and mental outlook of the patient when he sees that he is able to use his weakened muscles to move his extremities is often quite remarkable.

The next stage in the treatment of these patients is to provide exercise that will increase the muscle strength. This usually depends on the use of more extended periods of active exercise and in some cases the use of resistive exercise. It is only through the use of resistive exercise that a muscle will increase in strength. In determining the amount of

activity that a patient recovering from poliomyelitis can tolerate, it is important to remember that overfatigue or overstrain of a weakened muscle may result in a loss of strength in the neuromuscular unit, and a definite setback to the patient's progress. If increasing the patient's activity tends to encourage development of deformities, the activity should be curtailed for a longer period. In this stage of increasing activity many normal activities can be permitted if a weakened member is supported. At this time it is often well to have the patient wear straight-leg lock-knee brace if he has a total paralysis of one leg which is not expected to recover. Also in some cases with a latent scoliosis, development of the deformity may be prevented by the use of a back brace. The use of Canadian crutches will allow many patients more activity and relieve the weakened muscles of the lower extremities of some of the burden of balancing and weight-bearing.

The evaluation of the patient's physical capacities must be made from time to time by the orthopedist and the physical therapist. It is important to decide whether or not the patient can or should walk without braces. Often it is advisable to protect the joints of the weakened legs with braces which also make

the patient more stable in his walking and standing.

In the chronic stages of the disease which may last for many years, the possibility of benefit to the patient by orthopedic surgical procedures must be considered. A transplant of a tendon of a strong muscle to assist the action of a moderately weakened muscle may give a patient much more stability. Occasionally progressive deformities of the spine may require fusion of the spine. If deformities are developing or have developed in the foot, surgical procedures for arthrodesing the foot and ankle must be considered. Most surgical procedures can be delayed until two years or more following the acute stages. During this two year period, the child should be frequently checked to see that he is well co-ordinated in his muscle function and that deformities are not developing. Small uncooperative children who do not understand the problem may during this period grow into cooperative patients who can be instructed in the maximum efficient use of their weakened muscles. The regular follow-up of these children by the orthopedist and physical therapist over a prolonged period should be made a definite part of the treatment program.

## ANNOUNCEMENTS

- September 25—Meeting, Mississippi Valley Medical Editors' Association, St. Louis, Missouri.
- September 25-27—Meeting, Mississippi Valley Medical Society, St. Louis, Missouri.
- October 7-10—Fall Conference, Kansas City Southwest Clinical Society, Kansas City, Missouri.
- October 7-11—Course in Clinical Allergy, sponsored by American Academy of Allergy, Marquette University School of Medicine, Milwaukee, Wisconsin.
- October 9-12—Examinations, American Board of Ophthalmology, Chicago, Illinois.
- October 21-23—Assembly, United States Chapter International College of Surgeons, Detroit, Michigan.
- October 28-31—Fall Clinic, Oklahoma City Clinical Society, Oklahoma City, Oklahoma.
- October 28-November 1—Annual Assembly, Omaha Mid-west Clinical Society, Omaha, Nebraska.
- November 17-23—Inter-American Congress of Radiology, Havana, Cuba. Information may be secured through American College of Radiology, 20 North Wacker Drive, Chicago, Illinois.
- December 4-5—Meeting, Kansas State Board of Medical Registration and Examination, Kansas City, Kansas.
- April 28-May 2—Annual Session, American College of Physicians, Chicago, Illinois.
- MAY 12-15—ANNUAL MEETING, KANSAS MEDICAL SOCIETY, TOPEKA, KANSAS.

### National Society for Medical Research

The Association of American Medical Colleges, with the cooperation of 101 national scientific organizations, has announced the formation of a clearing house for information on medical studies and discoveries, to be known as the National Society for Medical Research. Headquarters will be in Chicago with Dr. Anton J. Carlson, professor emeritus of physiology at the University of Chicago, as president and Mr. Ralph A. Rohweder as executive secretary.

The advancement of research in medicine, biology, pharmacy, dentistry and veterinary medicine is the purpose of the society, and one of its important functions will be to analyze and expose the propaganda of small but highly vocal groups which object to the use of animals in the experiments without which medical science would still be in its infancy.

### New Director for National Foundation

Dr. Hart E. Van Riper, Scarsdale, New York, has been appointed medical director of the National Foundation for Infantile Paralysis, according to a recent announcement by Basil O'Connor, the organization's president. Dr. Van Riper has served as acting medical director since January.

What are the essentials of a program for the eradication of tuberculosis? First, a medical profession interested in the problem and familiar with modern methods of diagnosis and treatment. Next, complete diagnostic x-ray and laboratory facilities freely available to all physicians in a community and to the health department, regardless of the patient's ability to pay. Third, and equally important, a well-organized active health department with complete family records of all cases and a public health nursing service capable of teaching preventive measures in the home and maintaining effective contact between patient, doctor, and health department. *The Modern Attack on Tuberculosis*, Henry D. Chadwick, M.D., and Alton S. Pope., M.D., Commonwealth Fund, 1946.

During the period of the war, there occurred in the United States more than two deaths from tuberculosis for every three lives lost in combat by the armed forces of the United States. *J. Yerushalmi and I. M. Moriyama, Public Health Reports*, April 5, 1946.

## PRESIDENT'S PAGE

*To the Members of the Kansas Medical Society:*

The recent cancer drive in Kansas was quite successful and a considerable amount of money in excess of the quota was secured. Last week the first step in the reorganization of cancer work in Kansas was taken when a charter was secured for the Kansas Division of the American Cancer Society.

This organization will be completed by the election of directors and officers the latter part of this month, giving us a truly democratic organization with all authority springing from the county units. Of course the backbone of the organization will be the Women's Field Army. The proposed constitution provides for adequate medical representation on the Board of Directors.

The thing we wish to urge at this time on county societies is the initiation of projects for cancer diagnosis or treatment since, for the first time, there is money available for financing these enterprises. For the present, applications for funds should be made to Mrs. J. E. Johntz, commander of the Women's Field Army in Kansas, Abilene, Kansas. We must keep faith with the public by furnishing sound enterprises for the expenditure of these funds, enterprises that provide either diagnosis or treatment. The Cancer Committee of our state society will be glad to advise and help in the county problems.

For many years Dr. Cliff Nesselrode has headed the Advisory Committee of the Women's Field Army or our state Committee for the Control of Cancer or both positions at the same time. He and Mrs. Johntz are largely responsible for the success of the fight on cancer up to this time and will be actively identified with the new organization in the future.



H. M. Mies  
President

## EDITORIALS

### Railroad Retirement Acts

Before adjournment, the Congress of the United States passed HR 1362, which provides amendments to the Railroad Retirement Acts and the Railroad Unemployment Insurance Act. Among other changes and extensions of the original acts, HR 1362 sets up a system of sickness and maternity benefits for railroad employees, based on a graduated payroll tax which, after December 31, 1951, will be computed at  $6\frac{1}{4}$  per cent from the employees and  $12\frac{1}{4}$  per cent from the employer. President Truman is expected to sign this bill.

Historically, the medical profession has approved the payment of cash benefits out of social security funds for sickness and disability. However, this measure is the first instance of such payments by the federal government under any of its insurance programs. HR 1362 authorizes the Railroad Retirement Board to exercise extensive control over physicians and hospitals in the administration of sickness and maternity provisions of the Act.

It is time to pause a moment to consider the effects of the passage of this bill upon the medical profession. First, let us consider the economic aspects of the bill. After December 31, 1951, the total costs of such a bill will amount to  $18\frac{1}{2}$  per cent of the railroad employees' earnings. As cleverly stated in this bill,  $6\frac{1}{4}$  per cent is to be paid by the employee and  $12\frac{1}{4}$  per cent is to be paid by the employer. Basically, this can only mean, after all, that the employee is paying  $18\frac{1}{2}$  per cent of his total earnings for sickness and health benefits. After all, it is the man who does the work who must produce the money to pay the bills. It is impossible for corporations, even large ones such as the railroads, to assume, year after year, two per cent, four per cent, twelve and one-fourth per cent, added deductions and still remain solvent. The end result, therefore, is a true reduction in the amount of salary paid to the employee in order that the employer can pay a tax of  $12\frac{1}{4}$  per cent into a governmental agency to insure sickness and maternity benefits for railroad employees. This means, then, a lower standard of living for all railroad employees.

According to an analysis of this bill, it authorizes the Railroad Retirement Board to exercise extensive control over physicians and hospitals in the administration of sickness and maternity provisions of the Act. Would it be too much to assume that they anticipate forcing down the necks of the private hospitals and physicians of this country a program under which the hospitals would receive an insufficient

amount of income to meet the costs of taking care of these patients and that the fee schedule allowed the participating physicians would be also on a sub-standard rate. This has been our experience with certain groups of government subsidized patients in the past. Can we expect any more in the future?

The provisions of this act are no more than a small wedge driven into the field of the practice of medicine. Being mindful of the fact that the railroad employees comprise only a small percentage of our population, who is able to forecast what well organized group with a powerful lobby will be next in line for a similar act.

The government is most gratuitous in those instances where gratuity counts the most. For example, the government establishes in our midst government hospitals and then immediately sets up a wage scale for nurses and hospital attendants and workers that no local hospital can meet. Then they expect us to take care of, in our local institutions, the same class of patients at a per capita cost far under the actual cost of taking care of that patient. Can we expect more than this out of the Railroad Retirement Act?

It is customary in all business to have a yearly auditing and accounting. It would be worth while for the medical profession and the hospitals of our country to have an annual accounting. We should analyze this audit sheet and determine what may be credited to gain and what may be credited to loss. We should carefully analyze such groups of patients as would qualify under the provisions of the Railroad Retirement Act and other federally subsidized groups of patients. Then, we should go about in a systematic manner to eliminate those groups that financially and otherwise fall in the debt column. The medical profession has been played for suckers long enough. Remember there is strength in numbers and that our organized members hold the keys to the health of the nation.

### Hospital Construction Act

On August 13 the President signed the Hospital Survey and Construction Act, S. 191, and the Hill-Burton bill became law. The federal government will participate in the construction of private hospitals, establishing a new policy which, if operated in the future as now interpreted, will bring to private hospitals the assistance of federal funds with only a minimum of federal control.

Federal control will be asserted before the appropriation is approved. Once the hospital is completed and in operation, except for one detail, that hospital remains as independent as though only local funds were employed for its construction. The one exception applies to sale or transfer and to situations where a hospital closes. If, within 20 years, the

property is sold or transferred to an agency or individual not approved by the designated state agency, or if the hospital ceases to be a non-profit institution, or if the hospital closes, the United States retains the right to recover one-third of the then existing value of that hospital.

Only slightly amended in its last stages, the Hospital Construction Act authorizes the appropriation of 375 million dollars during the next five years to states on the basis of need. An additional three million dollars is granted for state-conducted surveys. Standards will be specified by the Surgeon General of the United States Public Health Service with the assistance of a hospital council of eight members to be appointed by the Federal Security Administrator.

Any state may initiate action by submitting a request to the Surgeon General for funds to carry out an inventory of existing hospitals, and to prepare a plan for the construction necessary to provide adequate care for all the people. In making the request, the states must designate a single state agency to carry out the survey and planning and must appoint a properly qualified advisory council to consult with the state agency. The proportionate share for each state of the total federal appropriation for survey and planning will be determined by the populations of the several states. However, federal funds must be matched by two to one in defraying the survey expenses.

Allotments for the actual construction of facilities will not be made until the state plan based on the survey findings has been approved. Construction allotments to individual states will vary in amount. Population will be one factor, and in addition the average per capita income will be used in the allotment formula in such a way that states with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita.

Applications for funds for individual construction projects must be channeled through the designated state agency. Here again, federal funds may not exceed one-third the cost of a project. Before any single project is approved by the Surgeon General, sufficient evidence must accompany the building request to show that two-thirds of the total cost of construction is available from other-than-federal sources, and that financial support is adequate for the maintenance and operation of the institution after completion.

The American Hospital Association announced on August 13 that in 40 states surveys are already under way and that only one state, Missouri, had taken no action. Surveys will be completed by October 1 in at least 11 states.

The survey in this state is completed and Kansas is one of the first five states to have accomplished this task. Years ago the Hospital Survey Committee of the Kansas Medical Society began studying the problem of adequate hospital distribution. Months ago this committee met with the Kansas State Board of Health, the Kansas Hospital Association, the Kansas State Nursing Association, architects, contractors and business leaders and authorized Dr. Beelman to start a Kansas survey. Almost immediately afterward an Advisory Hospital Commission to the State Board of Health was appointed by the Governor. Dr. A. R. Hatcher of Wellington, chairman of the Society committee on Hospital Survey, was named chairman of this commission. In this way the Society has retained a most active participation in this project.

Widespread interest in the program of adequate hospital distribution was evidenced during the 1945 session of the Kansas legislature. Enabling acts were passed permitting virtually all cities of the first or second class, all counties in the state, or cities and counties to vote bonds for hospital construction. At present 15 or more communities have already obtained funds and are ready to begin building as soon as materials become available. Interest increased immediately following the passage of S. 191 so that in the near future many other communities will also complete plans toward the establishment of hospital facilities. Dr. Beelman, of the State Board of Health, informed the Journal that many inquiries are being received.

It is understood, of course, that hospitals may be built without the use of federal funds. Should subsidies be desired, applications must first be made to the State Board of Health. They will be examined by the Advisory Hospital Commission of Kansas and, if approved, will be submitted to Washington. In Washington the entire state project for hospital construction will be studied. Where local need is established, and if local funds for completion of the project are shown to be adequate, the federal grant, not to exceed one-third the total cost, will be approved.

### Added Hospital Facilities

Under the provisions of Public Law 725, known as the Hospital Survey and Construction Act, an estimated \$933,750 per year for five years will be allotted to Kansas for hospital construction. This program is to be administered by the United States Public Health Service, under the direction of Surgeon General Thomas Parran.

On Tuesday, August 20, 1946, Dr. Parran announced the formation of a Division of Hospital Facilities to assist him in carrying out the provisions

of the act. This division will assist the states, their political sub-divisions and non-profit organizations in matters relating to study, construction and operation of hospitals. The division will also assist the surgeon general in preparing regulations, determining allotments and grants and in considering plans and projects. One of the standards which the surgeon general of the United States Public Health Service will probably require of participating states is a state-wide hospital licensing law. If this is correct, no federal money for this purpose can be received in Kansas until the legislature acts to meet this requirement.

It can be estimated that the communities of Kansas will receive federal grants over a period of five years amounting to approximately \$4,668,750 for hospital construction. At this writing, it seems that the state, county, city, community or non-profit organization will have to put up \$60 for every \$40 of federal aid on a matching basis to obtain these funds.

Apparently, in this program, there is a definite aim in view of placing federal grants where they will do the most good and where the community is sufficiently large to support the proposed institutions.

We can see in Public Law 725 a great opportunity to place hospital facilities in easy reach of every person in Kansas who is in need of those facilities. We can also see the possibility of improper distribution of these funds through political conniving and favoritism, thus placing hospital beds in communities that can only support those beds in economically flush times such as we now have.

Since most communities look to their physicians for guidance in matters pertaining to the health, it is up to our individual members to indulge in a lot of serious thought over the next few months, concerning anticipated hospital construction. The questions which we must be able to answer in order to serve our communities best are:

(1) What are the existing hospital facilities for the patients of our community?

(2) How many additional hospital beds are required to take care of the average needs of our communities?

(3) How many hospital beds can our community support financially?

(4) Where should this construction be made?

(5) Is it more economical to our patients to add 30 beds to an existing hospital of 30 beds in a town 15 miles away, where a larger area can be served, or to place it locally, thus requiring the duplication of many existing facilities such as x-ray and laboratory equipment, kitchens and laundry facilities, not to mention the personnel required to man those facilities efficiently.

(6) As physicians, can we not offer better medical and consultation service where there are several of us on the staff than in a small community hospital where our staff is very small?

Yes, we can see wonderful opportunities in this grant for Kansas medicine. We can see small to moderate sized hospitals placed in central locations, with good highway connections serving efficiently the community's hospital needs. We can see the medical service of Kansas communities improve because of increasing friendliness between the physicians of the community, stimulated by closer and more frequent contact, medical consultations, staff meetings and discussions. We can see those hospitals economically perpetuate themselves, and grow in tradition and size with the needs of the community. We can see the health standards of those communities rise.

On the other hand, we can see hospitals with too many empty beds, because of the optimism of too much money in the pocket, and the chance to get a federal grant. We can see hospitals that are badly in debt, getting supplies and food on a C.O.D. basis. We can see hospitals that are a liability instead of an asset to the communities they serve. We can see the health standards of those communities go down.

It is up to us to study the needs of our communities and make the proper recommendations. We must be able to give intelligent advice to county or city commissioners, civic club presidents, and all others interested in the program, stimulating them to action when there is definite need, and putting on the brakes when their enthusiasm is unjustified. It is our problem. The answer is not in the back of the book. We must work it out together.

### Surplus Commodities

Much controversy has arisen over the disposal of surplus commodities. It is not the purpose of this editorial to enter into that discussion, but merely to report information recently received from the War Assets Administration on this subject.

Periodically lists of available medical, dental and veterinary equipment are published. List Number Three was issued on June 1, 1946, and is available to anyone who requests this material. Correspondence concerning surplus commodities should be directed to the nearest regional office. For eastern Kansas this would be Mr. John E. Kirchner, Regional Director, War Assets Administration, Troost and Bannister Road, Kansas City, Missouri. Those physicians nearer Denver would write Mr. John A. Skeen, Regional Director, War Assets Administration, Commonwealth Building, 728 Fifteenth Street, Denver, Colorado.

(Continued on Page 408)

## Veterans Administration Agreement

Speed in completing disability examinations is one of the primary benefits the Veterans Administration and the veteran himself receive from a program such as that in operation in Kansas. For the successful continuation of this program it is essential that examining physicians complete and return the examination form as rapidly as possible. In an effort to further expedite this program, the Medical Service Center hereby announces a slight change in procedure policy.

Instead of having the examiner notify the Medical Service Center of the appointment time, the physician will now notify the veteran direct. The Medical Service Center will include all forms completely made out except for the date and hour of the appointment. The examiner will add that information and mail the notice direct to the veteran. This will save several days and considerable confusion. It is also recommended by the Committee on Veterans Administration Affairs that if an examiner cannot make an appointment for the veteran within a few days he should notify the Medical Service Center and return the material. This examination will then be sent to another physician in the locality.

During the past month Dr. Clyde B. Trees, orthopedist of Topeka, has been appointed to the Committee on Veterans Administration Affairs, thereby adding a specialist in another field to the group meeting each Friday noon to discuss examinations that, in the opinion of the director of the Medical Service Center, would not be acceptable to the rating board.

Each month on this page will be carried information pertaining to examinations. It is recommended by the committee that this material be retained for future reference since it summarizes nomenclature and procedures required under the agreement. The article on malaria printed below is a release just published by the Veterans Administration and represents the newest regulations regarding this disease.

### TREATMENT OF MALARIA

The following important points should be borne in mind in the treatment of the overseas veteran who presents himself to a VA field station with a presumptive diagnosis of malaria.

1. In practically all overseas veterans who still have malaria, the infection is due to *p. vivax*, since malaria due to *p. falciparum* was virtually eliminated among those who took suppressive treatment with quinacrine (atabrine), and very little malaria due to *p. malariae* was contracted.

2. The presumptive diagnosis of malaria should be confirmed by the examination of both thick and thin films and this examination should be repeated if initially negative. Usually, there is little likelihood of finding parasitemia when clinical symptoms are not present.

**CAUTION:** Self-medication by veterans just prior to application for medical care may mask the diagnosis of malaria.

3. If the veteran has clinical symptoms, he should be admitted to the hospital and be treated in bed during the acute attack, preferably with quinacrine (atabrine), as indicated in War Department Technical Bulletin No. 72, 10 July 1944.

This treatment is as follows: quinacrine 0.2 gm. every 6 hours for 5 doses to be followed by 0.1 gm. 3 times a day after meals for 6 days (total of 2.8 gm. in 7 days).

4. If severe nausea and vomiting are present, the treatment can be initiated by the intramuscular injection of 0.4 gm. of quinacrine, followed by one or two additional injections of 0.2 gm. at intervals of 8 hours, if necessary. The remainder of the course should be administered by mouth as outlined in paragraph 3 to give a total of 1.3 gm. of the drug in the first 48 hours and a total of 2.8 gm. in 7 days.

5. In the event that malaria parasitemia is discovered without clinical symptoms, it is recommended that a full course of treatment be given by mouth as outlined in paragraph 3. Hospitalization should be urged; but, if this is impossible, treatment may be given on an out-patient basis under adequate supervision by the physician.

6. Suppressive therapy is not advised for patients who require treatment for malaria in this country unless relapses occur at such short-time intervals as to cause incapacity or debilitation of the patient or to interfere seriously with his work. Under these circumstances, the following treatment schedule is recommended. Quinacrine 0.1 gm. daily with a full glass of water after a meal. This dosage may be continued for a period of 2 or 3 months. It should be emphasized that suppressive therapy is not expected to modify the natural course of the disease but is useful only to increase the interval between relapses (War Department Technical Bulletin Medical No. 136, January 1945).

7. Quinacrine intolerance is rare, but patients who cannot take the drug may be seen occasionally. Such cases may be treated with quinine sulfate or hydrochloride or by chloroquine (SN 7618). The quinine should be administered 1.0 gms. 3 times daily after meals for 2 days and then 0.6 gms. 3 times daily for 5 days (War Department Bulletin Medical No. 72). Chloroquine can be obtained from the United States Public Health Service through Central Office and will soon be available through commercial channels. It is given in doses of 0.3 gms. twice on the initial day, at 4-hour intervals, and once on each of two successive days.

8. In dealing with patients who have had repeated relapses, at least four or more, consideration may be given to the use of a special course of treatment, consisting of pamaquine (plasmochin-naphthoate) and quinine. As pamaquine is toxic, this treatment should not be employed routinely and it should be used only in selected cases. The patient should be treated in bed in a hospital where expert care can be given in case a toxic hemolytic reaction starts to develop. The patient's blood and urine should be closely observed to permit the early detection and vigorous management of a developing anemia. Because of the higher incidence of serious hemolytic reactions in colored or mixed races, this treatment should be undertaken only in members of the white race. The following course of treatment may be expected to effect a permanent cure in about 90 per cent of individuals who have had a number of relapses: pamaquine, 0.02 gm. given concurrently with 0.65 gms. of quinine sulfate every 8 hours for 14 days, a total of 0.84 gms. of pamaquine and 27.3 gms. of quinine. This treatment may be expected to cause a moderate but not dangerous degree of methemoglobinemia and also mild or moderately severe intestinal cramps.

9. Many veterans with relapsing vivax malaria will require reassurance concerning this disease.



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## **SEARLE**

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## KANSAS PHYSICIANS' SERVICE

After a delay of several months during which the Blue Cross reorganized its bookkeeping, the Kansas Physicians' Service sales staff is again at work. The experience during the first eight months of operation is better than had generally been expected. Approximately 8,000 persons are now covered by this voluntary prepaid medical care plan, and 875 physicians in Kansas have agreed to participate in the program. Each month many claims are authorized and paid.

Beginning September 1 a landmark in the experience of Kansas Physicians' Service will have been reached. The first participants enrolled as of January 1 will on that date become eligible for all benefits that are provided. The eight months waiting period has been completed for those persons, which adds to their benefits obstetrical services, tonsillectomies, and treatment for conditions existing prior to enrollment. Each month in the future more persons will become eligible for these total benefits.

In August the sales staff began its first community-wide enrollment drive. El Dorado was selected to be the city where this experience would begin. At the time this is written official reports are not available, but it appears that of all employee groups now enrolled with Blue Cross 40 or 50 per cent will also take Kansas Physicians' Service.

A large share of the credit for this splendid record is due the medical profession in El Dorado. Not only have these doctors united to approve this society sponsored project but of their own accord they placed a large advertisement in the newspaper declaring to the public their active participation in this plan.

During the coming months other Kansas communities will be selected for special drives. In each instance the medical profession will be notified beforehand. From the Executive Committee of Kansas Physicians' Service comes the sincere request that the medical society prepare for these events by speaking not only with individual patients who come to the office but by participating individually and as a group during the enrollment period.

Kansas Physicians' Service is the Kansas Medical Society. It is the one concrete reply that has yet been devised for those who would socialize the practice of medicine. Not only is this an answer but it gives to the individual a better program at a much lower cost than would be provided under federal regulations. It is of interest to the medical profession because, except for the manner in which the physician is paid, Kansas Physicians' Service in no way disturbs the present system of medical care.

### de Kruif and the Reader's Digest

"Demerol need not be disguised. It is God's own medicine." So rejoices Paul de Kruif, self-appointed impresario of medical progress to the lay public, in the June, 1946, issue of the Reader's Digest. The story is headlined, "The pain-fighting power of Demerol is as miraculous as that of morphine—without the opiates' danger of addiction." He describes the blessed relief from suffering given by Demerol to women in labor and to unfortunates in the agony of asthma and of gall and kidney stones—all with perfect safety. . . .

That Demerol possesses clinical merit is not questioned.

Its value and safety relative to morphine, dilaudid and other admittedly habit forming drugs may not be fully established for several more years. Meanwhile, to ballyhoo the drug to the public as one which may be given to relieve pain without danger of addiction is to completely ignore the reports of several investigators. Physicians are being besieged by sufferers from migraine, arthritis and a host of other painful and chronic ailments to give them "God's own medicine," dangled tantalizingly before their eyes as a safe drug by deKruif, who surely must have known that Demerol is regarded by law as a narcotic drug, and that its sale is just as tightly regulated as is that of morphine or cocaine. . . .

Doctors and informed laymen alike wonder why a magazine like the Reader's Digest, which has in the past enjoyed an enviable reputation for reliability, will jeopardize that standing by repeatedly publishing such material. Why are these articles not submitted to recognized medical authorities before publication? Does the public actually demand sensationalism rather than accuracy in its medical information? Do people enjoy deception so much that they welcome having their hopes of cure raised to the sky only to be cruelly dashed to earth? Or is there significance in the fact that de Kruif plugs proprietary drugs?—E. T. R. in *The Bulletin of the Los Angeles County Medical Association*, July 4, 1946.

### Society of Anesthesiology to Meet

All physicians interested in anesthesiology are invited to attend a dinner meeting of the Kansas City Society of Anesthesiology at 6:00 p.m., October 6, preceding the opening session of the Kansas City Southwest Clinical Society. Dr. John S. Lundy, president of the American Society of Anesthesiology, will be guest speaker. Complete information may be secured from Paul H. Lorhan, M.D., Director of Anesthesiology, University of Kansas Hospitals, Kansas City, Kansas.

### Clinical Society Meeting in Kansas City

The Kansas City Southwest Clinical Society will present its 24th annual fall conference in the Municipal auditorium, Kansas City, Missouri, October 7-10, 1946, with Dr. L. L. Bresette, president, in charge. Scientific sessions will be held in the Little Theater, and a number of prominent speakers will take part in the program. Dinners for alumni of the University of Kansas and the University Medical College will be held Wednesday evening, October 9.

A complete program of the conference appears in the September-October issue of the Kansas City Medical Journal, and copies may be secured from the office at 630 Shukert Building, Kansas City 6, Missouri. A list of speakers may be found in the advertisement on Page 407 of this Journal.

### College of Physicians to Meet

The American College of Physicians announces that its 28th annual session will be held in Chicago April 28-May 2, 1947, with Dr. David P. Barr, New York, president, in charge of the program. Dr. LeRoy H. Sloan, Chicago, is general chairman and will be in charge of the program of hospital clinics and panels. Complete information may be secured from Mr. Edward R. Loveland, executive secretary, 4200 Pine Street, Philadelphia 4, Pennsylvania.

*24th Annual Fall Clinical Conference*  
**The Kansas City Southwest Clinical Society**  
**Municipal Auditorium, Kansas City, Missouri**

*October 7, 8, 9, 10, 1946*

**GUEST SPEAKERS**

E. T. BELL, M.D., Pathology, Minneapolis  
 LOUIS A. BUIE, M.D., Proctology, Rochester  
 RICHARD B. CATTELL, M.D., Surgery, Boston  
 WARREN H. COLE, M.D., Surgery, Chicago  
 CHARLES A. DOAN, M.D., Int. Med. & Research, Columbus  
 A. I. FOLSOM, M.D., Urology, Dallas  
 L. H. GARLAND, M.D., Radiology, San Francisco  
 TINSLEY R. HARRISON, M.D., Int. Med. & Cardiology, Dallas

PAUL H. HOLINGER, M.D., OORL & Bronchology, Chicago  
 JOHN S. LUNDY, M.D., Anesthesiology, Rochester  
 PAUL B. MAGNUSON, M.D., Orthopaedics, Washington, D.C.  
 WALTER L. PALMER, M.D., Int. Med. & Gastroenterology, Chicago  
 HERBERT E. SCHMITZ, M.D., Obstetrics & Gynecology, Chicago  
 R. GLEN SPURLING, M.D., Neurosurgery, Louisville  
 WILLARD VAN HAZEL, M.D., Surgery, Chicago  
 E. H. WATSON, M. D., Pediatrics, Ann Arbor

**DAILY FEATURES:** Radio Broadcasts — Round Table Luncheons — Scientific Exhibits and Movies — Technical Exhibits — Women's Entertainment

**SPECIAL FEATURES**—Monday Evening: Clinicopathologic Conference.  
 Tuesday Evening: Stag Dinner and Entertainment.  
 Wednesday Evening: Alumni Dinners.

See Kansas City Medical Journal for complete program

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### Postgraduate Education Fund

The Kansas doctors who voluntarily contributed to a fund honoring returned medical officers from Kansas will be glad to know that this money is being used. Up to the present, 64 doctors have received financial assistance for the purpose of acquiring graduate education. Any medical officer who entered the service from Kansas is not only eligible but is most cordially invited to participate in this benefit.

The House of Delegates determined that these gifts should represent an expression of gratitude on the part of those who remained at home during the war. To date less than one-fourth the fund has been used, and the Postgraduate Education Committee, in a meeting last month, requested that additional information be published in the Journal stating again that all doctors eligible under this program who are taking graduate education are requested to write either the Executive Office, 406 Columbian Building, Topeka, Kansas, or Dr. H. H. Jones, Winfield. The letter need only state the veteran doctor's intention of taking graduate training and when and where this will be. After the letter has been approved by the committee, a check will be sent. While the gift will not nearly pay all expenses, it will at least assist in that direction and offer to the medical officer an expression of gratitude somewhat more tangible than words only.

Again to the doctors who donated to the postgraduate fund: The Committee on Postgraduate Education has received many letters of gratitude from recipients of this fund. Since the thanks is intended not for the committee but for each person who donated, a few sample comments are given below:

February, '46—"I wish to acknowledge and express to the Society my thanks for the help at this time."

July, '46—"I wish to acknowledge . . . and express my appreciation to the Kansas Medical Society."

May, '46—"Many of us who were overseas . . . have real need for 'refresher medical knowledge.' Your check will help."

June, '46—"Since my discharge from the Army the Medical Society has shown me nothing but the utmost kindness and consideration."

April, '46—"This check will certainly come in handy when I am paying for books and equipment."

June, '46—"The generosity of the individual contributors and the spirit of the fund are, I believe, more gratifying than the actual monetary benefit."

June, '46—"I want you to know that I appreciate the sentiment back of this. . . . Please express my thanks to everyone."

May, '46—"Obviously I cannot thank each member of the Kansas Medical Society, but I appreciate the 'helping hand.'"

May, '46—" . . . certainly a kind act and forethought by the members of the Kansas Medical Society. . . . It is my hope to carry on the high standard of the organization."

August, '46—"I certainly appreciate the spirit of the members of the Society who have contributed to the Graduate Education Fund, making this gift possible. You may be sure that is being used to good advantage."

After experience of something over a year with this program, the committee has two comments to make to the Society. First is the wish that the fund could have been large enough to enable payments sufficient to care for all expenses. Second is the hope that some day the Society will create a fund for postgraduate education for all members. This will be distributed in a different manner, perhaps to defray expenses of providing speakers. Details can

be decided later, but the value of a permanent fund for graduate education seems to have been established.

### New Doctors in Kansas

A number of doctors who have been serving in the armed forces, and others who have never before practiced in Kansas, are planning to open offices in the state soon. Among these is Dr. Michael Scimeca, recently discharged from the Army after 27 months' service, who will open an office in Caney. Dr. M. C. Marchand, who was associated in practice with Dr. H. C. Embry at Great Bend before entering the Navy, will practice in Macksville. It is also reported that Dr. Lindell C. Owensby, a graduate of the medical school at Washington University, will practice in Mankato.

The town of Bird City, which has had no resident physician, reports that Dr. Robert Gottschalk of Benkelman, Nebraska, will practice there. Dr. J. M. Sheater and Dr. E. M. Donald, both of whom were recently released from the armed forces, will practice in Caldwell and are making arrangements to re-open the hospital there on an open staff basis. Dr. Robert A. Crawford, formerly of Vermillion, South Dakota, has joined the staff of the Gage-Hall clinic at Hutchinson.

Dr. Charles Magee, who has been practicing in Wichita since his return from Army service, plans to open an office in Marion, and Dr. E. C. Beaty has announced the opening of his office in Parsons. Dr. V. G. Henry has moved to Anthony to practice in association with Dr. M. B. Flowers at the Community Hospital. Another man recently released from the Navy, Dr. R. E. Schnoebelen, will begin practice in Kansas, locating at Kinsley. Dr. Robert E. Allen, now serving in the Navy in St. Louis, will be released soon and will join the staff of the Student Health Service, University of Kansas, at Lawrence.

### Fall Conference in Oklahoma City

The Oklahoma City Clinical Society will present its 16th annual fall clinical conference in Oklahoma City, October 28-31, 1946. Lectures are dedicated to the needs of general practitioners, and 17 distinguished guests from various cities of the United States will present phases of medical advancement with which they have been identified from research and clinical viewpoints.

The complete program is designed for physicians who wish to acquire new ideas, restore forgotten points and polish up on useful information. There will be a large number of technical exhibits. Hotel reservations should be made immediately.

### Surplus Commodities

(Continued from Page 403)

Changes in the Act provide that individual veterans, physicians, dentists and veterinarians have priority over any other individual or institution except agencies of the federal government. This places the physician in a more favorable position than before with respect to other prospective purchasers of surplus commodities. Regional offices will advise concerning items, quantities, conditions, prices, availability and location of material and should be contacted for any business pertaining to surplus commodities.

# Information!

-ABOUT THE NEW



## Campbell's STRAINED BABY SOUPS

**Q. What are the ingredients  
in Campbell's Strained Baby Soups?**

A. Campbell's use carefully selected meats, cereals and those vegetables scientifically recognized as having the most desirable nutritive qualities. All the food properties are natural. Because Campbell's are accustomed to purchasing only selected meats and vegetables, the best is assured for Campbell's Strained Baby Soups.

**Q. What about vitamin and  
mineral retention?**

A. The latest scientific information has been drawn upon in the development of a cooking method to insure the effective conservation of vitamins and retention of minerals.

**Q. When should Baby be started  
on strained soups?**

A. Campbell's Strained Baby Soups can be started as early as any strained baby foods. Depending upon the baby, pediatricians recommend beginning between the ages of three and six months.

**Q. What about the flavor of  
Campbell's Strained Baby Soups?**

A. Every mother wants her baby's food to be palatable. Campbell's preparation and cooking methods have been devised to retain natural flavors insofar as possible. Babies develop food preferences early, accept some foods, reject others. Their acceptance of Campbell's Strained Baby Soups is indicated by the increasing demand for these soups wherever they have been introduced.

A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, New Jersey.

5

**KINDS:**

CHICKEN

BEEF

LAMB

LIVER

VEGETABLE

All in Glass  
Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . and in good flavor. Every resource of Campbell's Kitchens is devoted to that aim.

LOOK FOR THE RED-AND-WHITE LABEL

### Testimony on Physically Handicapped

It will be of interest to the physicians of Kansas to learn that the chairman of the Kansas Crippled Children Commission traveled to Washington to testify before the Subcommittee on Aid to Physically Handicapped of the Committee on Labor of the House of Representatives. This testimony is more interesting than some because it represents an agency that now operates under a form of socialized medicine. For the attitude of Mr. Charles J. Chandler of Wichita, of the Kansas Crippled Children Commission, we recommend you read the testimony which is printed below.

"We are grateful to have the opportunity to present testimony in behalf of those in Kansas who have a great interest in the crippled children of our state. We are deeply concerned with the measure you are considering, for, while there is no doubt need for adjustment in the legislation now on the federal statutes as it pertains to these children, this bill as now proposed will very seriously affect the program for the welfare of such children in Kansas, and, we believe, elsewhere.

"It is not the intention to make a detailed recital of the operation of the program for the care of the crippled child in Kansas. In order, however, that you may have an understanding of the effect of this proposed legislation in a typical state may it be said that for over 15 years the state of Kansas has furnished annually, from its own tax revenue, \$200,000 for the medical care of its crippled children. To this, under the Maternal and Child Welfare Act as amended in 1939 the Department of Labor, through the Children's Bureau, has, in recent years, contributed amounts varying from \$93,722 in 1941 to \$36,250 in 1943, or an average of \$51,991 over the years 1940 to 1945 inclusive, to provide administration facilities, visiting nurses, and other valuable services in supplement to the state's program. It will, therefore, be seen at the present time the state is contributing approximately three-fourths of the money administered and the federal government the other one-fourth.

"Now there is introduced into Congress the legislation which you are considering and which, under Title Two thereof, makes it mandatory that the Crippled Children Commission of Kansas, if it is to continue to secure these federal funds in the future, must submit to the Children's Bureau each year a plan which is basically contrary to the statutes of our state, and would make it necessary for us to abandon the use of federal funds in our program, or insist that the legislature of Kansas abolish principles which we feel are basically inherent to sound self-government.

"The most important of the provisions in the law which are disturbing to us is that portion of Part Three in Section 205 which, we are advised, requires that the plan to be submitted to the Children's Bureau each year must make the services and facilities of the Commission available to all residents of the state regardless of their ability to pay for the care and treatment they receive. If this is the intention of the framers of this bill, then we in Kansas are faced with the alternative of foregoing the receiving of our share of the federal funds allotted for the use of crippled children throughout the nation, or of asking our legislature to inaugurate a program of state medicine so far as the care of our crippled children is concerned. It is our judgment that the Kansas legislature could not, and would not, do this. There cannot, to our way of thinking out in Kansas, be any emergency at this time or justification otherwise which should make the state or federal government responsible for the care of anyone who is financially able to pay his own way. We most sincerely feel that such a move would seriously undermine the individual responsibility of our citizens which we believe to be a basic re-

quirement for the successful continuance of our form of government. We most respectfully and most earnestly urge the amendment of Section 205 of the bill under consideration to include therein a provision that the medical care, under the plans to be submitted, will not be made available without cost to those who can justly pay for part or all of the services rendered.

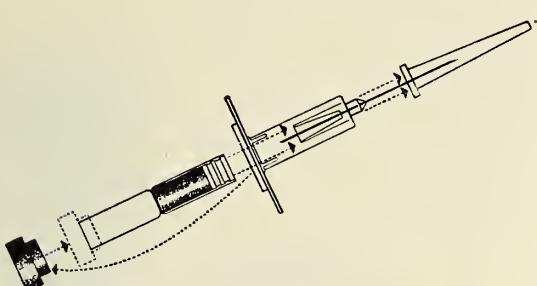
"The bill further provides that after July 1, 1950, the crippled children programs to receive federal support must be the responsibility of the state health agency in each state. Today these programs are administered by various bodies and it is understandable that there might be a desire in the interest of uniformity to put them under one type of agency in all states. In our judgment, however, this change is not justifiable where an agency such as a Crippled Children Commission is functioning effectively, and has had a record of many years of successful administration. The functions of the State Board of Health are primarily those of epidemic control, routine sanitary inspection, dissemination of information regarding contagious diseases, and in the field of education generally. The administration of a state program for the care of the crippled child can, in our judgment, be much more effectively carried forward by an independent commission, and we believe the records of the soundly constituted commissions in a number of states will justify this assertion. Since 1931, when the Crippled Children Statute was placed on the books of Kansas, the Crippled Children Commission has held 195 clinics throughout the state in which 10,255 examinations have been made, and has hospitalized over 9,300 children and given them, we believe, a quality of care and treatment, attention and interest, that only a sympathetic, intelligent, non-political and independent organization can provide.

"An asset of inestimable value to any program such as this is the interest and attention of capable and intelligently sympathetic citizens. This is more possible, we feel, when the program is in the hands of a competent non-political commission than in any other manner. It would be a very great loss to Kansas, and, no doubt, the situation is similar in other states where the program is capably administered by a separate organization, if the responsibility for the crippled child became just another function of the state department of health, as ably as that department of our state government in Kansas is administered at this time. It is, therefore, the very earnest request of those of us out in Kansas who are deeply interested in the crippled child, that the portion of Part Four of the above named Section 205, which is intended to eliminate the functioning of independent crippled children commissions, be amended to provide that in states where such a commission is effectively administering its program that it shall not be disturbed.

"We appreciate the opportunity to present these suggested amendments to the proposed legislation, and respectfully request the Committee's favorable consideration of them."

Our ideas of sanatorium treatment are changing. Perhaps the most important change is the gradual realization of the influence of mental and emotional factors upon organic disease. For too many years, attention has been focused on the organ in which tuberculosis disease has developed, and physicians have ignored the fact that tuberculous patients are also human beings. Contributing to this attitude has been the false assumption that tuberculous persons are always cheerful, happy, and hopeful of the future. *Ann'l Rep't., Cattaraugus Co. (N.Y.) Health Dept., 1944.*

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That's just about how quickly and easily you can get ready for an injection of Abbott's Romansky formula of penicillin calcium in oil and wax when you use a new sterile Disposable Cartridge Syringe. Here's why: No further sterilization of syringe and needle. No drying. No complications from traces of water. No trouble of drawing the fluid from a bulk container. No wasted suspension.

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### New Doctors of Medicine

The Kansas State Board of Medical Registration and Examination has announced the names of a number of doctors who have been issued licenses to practice within the state. The following persons were awarded licenses on the basis of examinations or by reciprocity:

- Akey, Robert M., Pittsburg, Kansas  
 Allen, William R., Kansas City, Kansas  
 Anderson, William D., Claremore, Oklahoma  
 Atcheson, Bellfield, Kansas City, Kansas  
 Austin, John O., Garden City, Kansas  
 Balogh, Charles J., Wichita, Kansas  
 Barnard, Ruth I., Topeka, Kansas  
 Barrett, Harle V., St. Marys, Kansas  
 Barry, John W., Kansas City, Missouri  
 Becker, Paul G., Newton, Kansas  
 Beine, William R., Coffeyville, Kansas  
 Braun, William T., Pittsburg, Kansas  
 Bressette, James E., II, Kansas City, Kansas  
 Brewer, Marshall A., Kansas City, Kansas  
 Brinton, Edward S., Wichita, Kansas  
 Brookens, Norris L., Topeka, Kansas  
 Brownlee, William E., Kansas City, Missouri  
 Bunting, Williston P., Kansas City, Missouri  
 Burger, Junior D., Menlo, Kansas  
 Burns, Warren W., Manhattan, Kansas  
 Byers, Philip L., Kansas City, Kansas  
 Cain, Alvin R., Kansas City, Missouri  
 Chappell, Ewin S., Topeka, Kansas  
 Choy, James King Lee, Topeka, Kansas  
 Christ, Vincent A., Leavenworth, Kansas  
 Christman, Edmund E., Joplin, Missouri  
 Clement, Conrad C., Olathe, Kansas  
 Combs, Peter S., Leavenworth, Kansas  
 Conrad, Joseph A., Dodge City, Kansas  
 Conroy, John C., Atwood, Kansas  
 Crouch, Boyden L., Kansas City, Missouri  
 Crowley, Edward X., Jr., Chicago, Illinois  
 Cruse, Donald R., Kansas City, Missouri  
 Cutcliff, Daniel J., Omaha, Nebraska  
 Dieter, Donald D., New Orleans, Louisiana  
 Dreyer, William F., Independence, Kansas  
 Earl, Charles N., Cottage Grove, Oregon  
 Ewing, Thomas D., Lyons, Kansas  
 Fink, Abraham A., Kansas City, Kansas  
 Fink, Howard P., Winfield, Kansas  
 Flack, Frank E., Wichita, Kansas  
 Francis, Norton L., Wichita, Kansas  
 Friesen, Florence C., Greensburg, Kansas  
 Garner, Fay L., Manhattan, Kansas  
 Gilliland, James O., Herington, Kansas  
 Gloyne, Howard F., Kansas City, Kansas  
 Gouldman, Edwin F., Topeka, Kansas  
 Hale, Ralph, Kansas City, Missouri  
 Handley, Richard N., Omaha, Nebraska  
 Harden, Bernard L., Parsons, Kansas  
 Hatcher, Albert C., Wellington, Kansas  
 Heasty, Robert G., Manhattan, Kansas  
 Hershorn, Simon E., Omaha, Nebraska  
 Hoak, Carl G., Kansas City, Missouri  
 Hoedemaker, Edward D., Topeka, Kansas  
 Hoff, Donald E., Wichita, Kansas  
 Holley, Charles A., Kansas City, Missouri  
 Huebert, Dan W., Halstead, Kansas  
 Huebert, Dean A., Halstead, Kansas  
 Hunnicutt, Cecil G., Sabetha, Kansas  
 Hunter, Charles A., Jr., Topeka, Kansas  
 Jenkins, Melvin E., Jr., Kansas City, Kansas  
 Jenson, Robert L., Colby, Kansas  
 Jewell, Maurice L., Kansas City, Missouri  
 Johnson, Charles A., Kansas City, Kansas  
 Johnson, Edward A., Kansas City, Kansas  
 Johnson, James S., Kansas City, Missouri  
 Johnson, Lawrence W., Osage City, Kansas  
 Jones, Asa C., Jr., Horton, Kansas  
 Jones, Rodney H., Goodland, Kansas  
 Jones, Sam, Hutchinson, Kansas  
 Kasha, Robert L., Valley Center, Kansas  
 Kendrick, J. Gilleran, Wichita, Kansas  
 Kerr, Richard K., Lincoln, Kansas  
 Kieber, Robert W., St. Joseph, Missouri  
 Kinsey, Mary E., Kansas City, Kansas  
 Kline, Duane M., Jr., Baxter Springs, Kansas  
 Larsen, William E., Wichita, Kansas  
 Litton, Lyle D., Stockton, Kansas  
 Litton, Lynn O., Stockton, Kansas  
 Lloyd, Donald E., Emporia, Kansas  
 Lloyd, Harvey L., Kansas City, Kansas  
 Lyons, Dave J., Pittsburg, Kansas  
 McGowan, Edwin C., Victoria, Kansas  
 McNickle, Jerry H., Ashland, Kansas  
 McLain, Kenneth, Burrton, Kansas  
 Macrae, Donald H., Topeka, Kansas  
 Marchbanks, James J., Pittsburg, Kansas  
 Mathews, Hugh H., Hoyt, Kansas  
 Menaker, Jerome S., Wichita, Kansas  
 Miller, Don E., Kingman, Kansas  
 Miller, Herbert C., Jr., Kansas City, Kansas  
 Monroe, Carroll D., Selma, Kansas  
 Mosser, Donn G., Wichita, Kansas  
 Mueller, Adolph R., Leavenworth, Kansas  
 Mullen, Leo M., Kansas City, Missouri  
 Murphy, Franklin D., Kansas City, Missouri  
 Myers, Wilson E., Kansas City, Missouri  
 Nelson, Gust H., Jr., Kansas City, Missouri  
 Nice, Gerald W., Parsons, Kansas  
 Nininger, Eugene V., McPherson, Kansas  
 Nunemaker, Marion E., Langdon, Kansas  
 Owensby, Lindell C., Mankato, Kansas  
 Parker, Bernard B., Topeka, Kansas  
 Parker, Clark T., Emporia, Kansas  
 Parker, Elmer L., Kansas City, Missouri  
 Passmore, Mildred R., Chicago, Illinois  
 Peck, James H. A., St. Francis, Kansas  
 Peterson, Van D., Jr., Kansas City, Missouri  
 Phelps, Stephen R., Topeka, Kansas  
 Poling, Fowler B., Halstead, Kansas  
 Proctor, James T., Wichita, Kansas  
 Read, William T., Coffeyville, Kansas  
 Reals, William J., Omaha, Nebraska  
 Reed, Darwin C., Wichita, Kansas  
 Reed, Rhea, Norton, Kansas  
 Reedy, Richard N., Omaha, Nebraska  
 Reitz, Carl H., Kansas City, Missouri  
 Rhoades, Arthur B., Merriam, Kansas  
 Rich, Eldon S., Newton, Kansas  
 Richards, Francis L., Coffeyville, Kansas  
 Richert, Robert C., Newton, Kansas  
 Robbins, Agnes L., Kansas City, Kansas  
 Roberts, Howard E., Topeka, Kansas  
 Robertson, Howard T., Concordia, Kansas  
 Robinson, Leo D., Iola, Kansas  
 Robinson, Murray E., Goodland, Kansas  
 Ruzicka, Lawrence J., Belleville, Kansas  
 Sandell, James E., McPherson, Kansas  
 Saxe, Lovis P., Trenton, New Jersey

**to combat**



## **mental depression in the menopause**

"... because the involutional period is fraught with sadness the different forms of mental disorder of this age may be highly colored with mental depression."<sup>\*</sup>

Severe menopausal depression, marked by apathy and psychomotor retardation, is frequently progressive. Hence, if not promptly and effectively treated, it may seriously impair the patient's normal capacity for useful living.

In such cases, Benzedrine Sulfate helps to overcome the depression, to restore optimism and to reawaken the savor and zest of life. Needless to say, Benzedrine Sulfate is not indicated in the casual case of low spirits, as distinguished from true prolonged mental depression.

<sup>\*</sup>Hinsie, Leland E.: *The Person in the Body, an Introduction to Psychosomatic Medicine*, New York, W.W. Norton & Co., 1945, p. 223.

Tablets and Elixir

**benzedrine sulfate**



(racemic amphetamine sulfate, S.K.F.)

Smith, Kline & French Laboratories, Philadelphia, Pa.

Schafer, Walter L., Wichita, Kansas  
 Schaffer, Richard C., Kansas City, Missouri  
 Schnoebel, Rene E., Kinsley, Kansas  
 Scott, John R., Newton, Kansas  
 Seitz, Joseph E., Ellsworth, Kansas  
 Shifrin, Alexander, Kansas City, Missouri  
 Shinkle, Anna I., Mound City, Kansas  
 Shinkle, William C., Mound City, Kansas  
 Siegel, Carl D., Ellis, Kansas  
 Sixbury, Carl E., Oberlin, Kansas  
 Smith, William T., Topeka, Kansas  
 Staggs, William A., Kansas City, Missouri  
 Steeples, George L., Jr., Wichita, Kansas  
 Stockton, Raymond W., Kansas City, Kansas  
 Stortz, Robert B., Galena, Kansas  
 Street, Glenn Q., Jr., Wichita, Kansas  
 Surber, Maxine A., Wichita, Kansas  
 Svoboda, Charles R., Holyrood, Kansas  
 Tanner, John W., Omaha, Nebraska  
 Thurlow, John F., Kansas City, Missouri  
 Tilden, James F., Wichita, Kansas  
 Tinterow, Maurice M., Wichita, Kansas  
 Trees, Donald P., Wichita, Kansas  
 Treger, Donald M., Independence, Kansas  
 Virden, Herbert H., Kansas City, Missouri  
 Voth, Harold W., Goessel, Kansas  
 Wallace, Deane D., Norwick, Kansas  
 Walton, Lowell C., Kansas City, Missouri  
 Wartman, Calvin, Piercerville, Kansas  
 Weinberg, Bernhard J., Coffeyville, Kansas  
 Whallon, Jacob T., Wichita, Kansas  
 Wilbur, Ronald E., Kansas City, Missouri  
 Wilen, Carl J. W., Manhattan, Kansas  
 Winkle, Vernon M., Topeka, Kansas  
 Wright, Emory N., Jr., Salina, Kansas  
 Young, Clarence F., Kansas City, Kansas  
 Ziegler, James E., Junction City, Kansas

## MEMBERS

Dr. E. N. Robertson, Concordia, announces that Dr. John Dixon, formerly of Kansas City, will soon be associated with him in practice. A graduate of the University of Kansas School of Medicine, Dr. Dixon spent several years in the Army and was recently released from the service.

\* \* \*

Dr. C. H. Munger, Emporia, has returned to his duties as Lyon county health director after an absence of several months while he did graduate work in public health at the University of Michigan.

\* \* \*

Dr. H. P. Gray, who has been practicing in Seneca for eight years, has joined the Veterans Administration staff and is now practicing internal medicine at Winter General hospital, Topeka. His practice in Seneca is being taken over by Dr. J. Howard Gilbert of Tonkawa, Oklahoma, who was recently released from the Army medical corps.

\* \* \*

Dr. Kenneth L. Druet has returned to his practice in Salina after having spent 46 months in military service. As a lieutenant colonel, Dr. Druet served as chief of the bronchopulmonary, thyroid and arthritis section at William Beaumont general hospital, El Paso, Texas.

\* \* \*

Dr. Russell Nevitt, who recently opened an office in Iola after his discharge from the Army, has been named

Allen county health officer, succeeding Dr. A. R. Chambers, resigned.

\* \* \*

Dr. Charles F. Haughey, who has been practicing in Anthony for four years, is planning to open an office in Tribune soon.

\* \* \*

Dr. Robert F. Harp, Highland, announces that he is moving to Hoxie and will open an office there.

\* \* \*

Dr. Charles R. Magee, formerly of Wichita, has opened an office in Marion and is now practicing there.

\* \* \*

Dr. Samuel T. Thierstein, Whitewater, has announced that he is now associated with the Olney clinic at Lincoln, Nebraska, as obstetrical and gynecological specialist.

\* \* \*

Dr. William C. Menninger, Topeka, has been appointed a member of a clinical advisory committee to foster close relations between civilian and Army medicine, according to an announcement made recently by Secretary of War Patterson.

\* \* \*

Dr. Robert M. Drisko, who formerly practiced in DeSoto, is now in New York City for three years study in orthopedic surgery.

\* \* \*

Brig. Gen. William C. Menninger, who served as director of neuropsychiatric consultants division of the Surgeon General's office in Washington during the war, is now on terminal leave and has returned to Topeka. He will practice at the Menninger Foundation and will serve as consultant to Winter General hospital.

\* \* \*

Dr. Oliver Martin, who practiced in Baxter Springs before entering the service, recently announced his association with the Salina Clinic.

\* \* \*

Dr. J. J. Brenneman, Moundridge, will leave this month for the Philippine Islands to become a medical missionary for the Mennonite Central Relief Committee. The office in Moundridge will be taken over by Dr. Delbert V. Preheim, who recently returned from similar work in Puerto Rico.

\* \* \*

Dr. James G. Lee, Jr., who has been assisting Dr. K. F. Bascom in Manhattan recently, took over his father's practice in Bonner Springs during August and went to Iowa City September 1 to begin a residency in obstetrics and gynecology.

\* \* \*

Dr. Malcolm C. Murfitt, who was discharged from the Army in June, has announced the opening of an office in Lindsborg.

\* \* \*

Dr. C. F. Taylor, superintendent of the state sanatorium at Norton, was elected president of the American Academy of Chest Physicians at a meeting held at San Francisco in June.

\* \* \*

Dr. M. D. McComas, Jr., Courtland, has made arrangements to spend part of each week in an office he is opening in Jamestown.

\* \* \*

Dr. Charles H. Johnson, recently discharged from the Army medical corps, has announced the opening of an office in Osawatomie. Before entering the service, Dr. Johnson practiced in Kinsley.

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the extra assurance  
with every tube of  
**Koromex Jelly**

**TIME TESTED  
CLINICAL  
RECORD**



prescribe...

with confidence



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The Bethel clinic at Newton has announced that Dr. Robert W. Myers, former teacher of anatomy at the University of Kansas School of Medicine and resident surgeon at the school, has been added to its staff. His work at the clinic will be confined to surgery.

\* \* \*

Dr. E. C. Bryan, Erie, announces that he will be associated in practice in the future with Dr. Howard Dunham, who was recently separated from the Navy. The partnership will practice at the Erie clinic.

\* \* \*

Dr. Albert Martin, Coffeyville, has announced that his brother, Dr. Hubert Martin, was discharged from the Army last month and will be associated with him in practice in Coffeyville soon.

\* \* \*

Dr. Robert W. Robb, a member of the medical staff at the Osawatomie state hospital since 1929, has resigned to become assistant superintendent at the Iowa state hospital at Independence, Iowa. He was engaged in private practice in Olathe before going to Osawatomie.

\* \* \*

Dr. Dale C. McCarty, who practiced at Nashville before becoming a company physician for the Firestone Tire and Rubber company at Akron, Ohio, is planning to open an office in Medicine Lodge soon. During the past five years he has been serving in the Army medical corps.

\* \* \*

Dr. Fay L. Garner, formerly of Seward, Nebraska, is now associated in practice with Dr. Ralph G. Ball, Manhattan. Now on terminal leave from the Army, Dr. Garner served as a major overseas in the 125th Evacuation hospital in France and Germany, a hospital unit commanded by Dr. Ball.

\* \* \*

Dr. Byron W. Walters, who has been practicing in McPherson and maintaining a part-time office in Marquette, has moved to Marquette to continue his practice there on a full-time basis.

\* \* \*

Dr. Russell J. Maxfield, who was recently released from the Navy, is now associated in practice with Dr. O. W. Miner, Garden City.

\* \* \*

Dr. Robert C. Gribble, who practiced in Spearville before entering the Army four years ago, has announced the opening of an office in Dodge City.

\* \* \*

Dr. Leo F. McKee has begun practice in Cottonwood Falls. During the past four years he has served in the armed forces, and before that time he was located in Hiawatha.

\* \* \*

Dr. Frederic O. Epp, formerly of Wichita, has moved to Valley Falls and is now practicing there.

\* \* \*

Dr. E. G. Coyle, Coffeyville, has announced that his son, Dr. John F. Coyle, who was released from the Navy in July, will be associated with him in practice.

\* \* \*

Dr. C. C. Hawke, Winfield, was elected president of the new Cowley County Health board at a meeting held in July. Dr. Thomas R. Hood, county health officer, was named secretary-treasurer of the board.

\* \* \*

Dr. William G. Weston, Dr. Garland L. Campbell and Dr. George Arack are members of a medical group known as the Weston clinic, practicing in Arkansas City.

The Public Relations Office of Dibble General Hospital, Menlo Park, California, has released the following citation for the Army Commendation Ribbon for Lt. Col. Maurice A. Walker, Kansas City, who was recently released from the service: "For meritorious service as Safety Consultant, Baxter General Hospital, Spokane, Washington, from 1 January 1944 to 15 October 1945. In addition to his duties as chief of surgical service, Col. Walker was responsible for conducting and maintaining a safety program which, through his zeal and unremitting efforts, resulted in an outstanding record of 4,312,316 manhours of work accomplished without loss of time due to accidents. His superior performance of duty contributed materially to the welfare of employees at this hospital."

\* \* \*

Dr. Edwin P. Deal, who has been practicing in Dighton, has moved to Greensburg and is opening an office there.

\* \* \*

Dr. Ernest P. Carreau, who was recently released from the Navy, has announced the opening of an office in Mulvane.

\* \* \*

Dr. William J. Hatfield, who formerly practiced in Colony, has retired and is now living in Topeka.

\* \* \*

Col. R. W. Van Deventer advises the Journal that his address has changed from Veterans Administration Facility, Muskogee, Oklahoma, to Wellington, where he formerly practiced.

\* \* \*

Dr. W. J. Pettijohn, who has been practicing in Kiowa, has moved to Russell.

\* \* \*

Dr. Howard E. Snyder, Winfield, is one of a group of 58 civilian surgeons appointed as consultants to the Secretary of War through the Surgeon General, according to a recent announcement made by the War Department. Located strategically throughout the country, the specialists were appointed as part of the Army Medical Department's program to maintain the highest possible standards of medical practice. Their aim will be to evaluate, promote and improve, wherever possible, the quality of medical care given the American soldier.

### County Societies

Members of the Crawford County Medical Society entertained their wives at a social meeting at the Hotel Besse, Pittsburg, June 27. Dr. F. H. Rush welcomed the guests and Mrs. C. H. Benage responded. Dr. D. H. Woods introduced other guests who presented a musical program.

\* \* \*

Thirty members of the Central Kansas Medical Society, representing seven counties, attended a quarterly meeting held at Russell June 27. Afternoon and night sessions were held with Dr. Peter T. Bohan, Kansas City, as guest speaker.

Mass surveys of chests with x-rays often find, but do not necessarily identify, disease. *Editorial, The Ohio State Medical Journal, April, 1946.*

\* \* \*

Tuberculosis is always a dangerous disease. In the Navy it has exceptional significance because of the unavoidable close quarters of existence, the importance of continuous physical fitness and the rich resources available for its control by exclusion, prevention, detection and care. *Emil Bogen, M.D., and G. H. Strickland, M.D. The Am. Rev. of Tbc., Dec., 1945.*

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Graduate School of Medicine**  
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**SURGERY**—Two Weeks Intensive Course in SURGICAL TECHNIQUE starting September 23rd, and every four weeks thereafter.

Four Weeks Course in GENERAL SURGERY starting September 9, October 7.

One Week Course in SURGERY OF COLON & RECTUM starting September 16, October 14.

One Week Course in THORACIC SURGERY starting September 23.

**GYNECOLOGY**—Two Weeks Intensive Course starting October 21.

One Week Personal Course in VAGINAL APPROACH TO PELVIC SURGERY starting September 16, October 14.

**MEDICINE**—Two Weeks Intensive Course starting September 23, October 21.

**GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.**

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## ANNOUNCING THE SIXTEENTH ANNUAL CONFERENCE OF THE OKLAHOMA CITY CLINICAL SOCIETY

OCTOBER 28, 29, 30, 31, 1946

### DISTINGUISHED GUEST LECTURERS

Harrison H. Shoulders, M.D., PRESIDENT, THE AMERICAN MEDICAL ASSOCIATION, Nashville, Tennessee

- Charles L. Brown, M.D.**, MEDICINE, Hahnemann Medical College Philadelphia, Pennsylvania.
- Samuel A. Cosgrove, M.D.**, OBSTETRICS, Clinical Professor of Obstetrics, Faculty of Medicine, Columbia University; Medical Director and Superintendent and Chief of the Staff, Margaret Hague Maternity Hospital, Jersey City, New Jersey.
- Claude F. Dixon, M.D.**, SURGERY, Professor of Surgery, Mayo Foundation, Postgraduate School, University of Minnesota, Rochester, Minnesota.
- Austin I. Dadson, M.D.**, UROLOGY, Professor of Urology; Urologist to Hospital Division, Medical College of Virginia, Richmond, Virginia.
- Philip S. Hench, M.D.**, MEDICINE, Consultant and Head of a Section on Medicine; Chief of the Department for Rheumatic Diseases; Associate Professor of Medicine, Mayo Foundation, Postgraduate School, University of Minnesota, Rochester, Minnesota.
- Waldo E. Nelson, M.D.**, PEDIATRICS, Professor of Pediatrics, Chief of the Pediatric Department, Temple University School of Medicine, Philadelphia, Pennsylvania.
- Paul Padgett, M.D.**, MEDICINE, Assistant Professor of Medicine, Johns Hopkins University School of Medicine; Veterans Administration, Fort Howard, Maryland.
- Walter L. Palmer, M.D.**, MEDICINE, Professor of Medicine, Department of Medicine, University of Chicago, Chicago, Illinois.
- Rawley M. Penick, Jr., M.D.**, SURGERY, Associate Professor of Clinical Surgery, Tulane University School of Medicine, New Orleans, Louisiana.
- Lea G. Rigler, M.D.**, RADIOLOGY, Professor and Chief of the Department of Radiology and Physical Therapy, University of Minnesota School of Medicine, Minneapolis, Minnesota.
- Richard H. Sweet, M.D.**, SURGERY, Instructor in Surgery, Harvard Medical School, Boston, Massachusetts.
- Richard W. Te Linde, M.D.**, GYNECOLOGY, Professor Gynecology; Chief Gynecologist, Johns Hopkins University School of Medicine, Baltimore, Maryland.
- James E. M. Thomsen, M.D.**, ORTHOPAEDIC SURGERY, Lecturer in Plastic Surgery to the College of Dentistry, University of Nebraska; President, American Academy of Orthopaedic Surgeons, Lincoln, Nebraska.
- O. E. Van Alyea, M.D.**, OTOLARYNGOLOGY, Clinical Associate, University of Illinois, College of Medicine, Chicago, Illinois.
- Shields Warren, M.D.**, PATHOLOGY, Assistant Professor of Pathology, Harvard Medical School, Boston, Massachusetts.
- Alan C. Waads, Sr., M.D.**, OPHTHALMOLOGY, Professor of Ophthalmology; Ophthalmologist-in-chief, Johns Hopkins University School of Medicine, Baltimore, Maryland.

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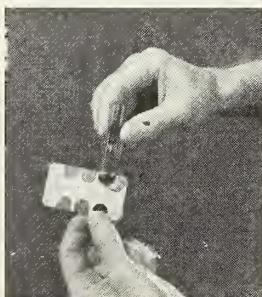
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### DEATH NOTICES

#### CHARLES REES TOWNSEND, M.D.

Dr. Charles R. Townsend, 75, a member of the Nemaha County Medical Society, died at St. Joseph, Missouri, April 4, after a long illness. A graduate of Louisville Medical College and Jefferson Medical College in Philadelphia, Dr. Townsend began practice in Everest in 1901, later moving to Troy and Centralia. He was practicing in Centralia at the time of his death.

\* \* \*

#### HENRY MILTON STEWART, M.D.

Dr. Henry Milton Stewart, 74, a member of the Reno County Medical Society, died August 15 of coronary heart disease. He was graduated from Rush Medical College in 1898 and was licensed in 1901. He had practiced in Hutchinson for many years, specializing in eye, ear, nose and throat work.

\* \* \*

#### FRANK ELLSWORTH COFFEY, M.D.

Dr. Frank E. Coffey, 55, orthopedic surgeon at Hays, died August 28. A graduate of the University of Kansas School of Medicine in 1920, Dr. Coffey was licensed that year. In addition to membership in the Central Kansas Medical Society, he was a member of the American Board of Orthopedic Surgery and the American Academy of Orthopedic Surgeons.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and textbooks.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

**THE UNIVERSITY OF KANSAS  
SCHOOL OF MEDICINE**

## BOOK REVIEWS

*Fractures, Dislocations and Sprains.* Fourth Edition. By John Albert Key, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. Published by C. V. Mosby Company, St. Louis, Missouri. 1322 pages. Price \$12.50.

This book has proved itself through its earlier editions and the present one will keep up the excellent record established when the book was first published. Profiting by the experiences of the recent war, the section on the treatment of compound fractures has been extensively revised and improved, and those of the spine and hip have received considerable alterations, due to the changes in concepts of treatment of injuries in these localities.

The book is an excellent reference book, in which any desired material is readily found, and it is also a very readable book if one wishes to read more extensively than for a specific injury. One of the most striking features is the repeated presentation of two opposite methods of treatment, one favored by each of the two co-authors. Each has been satisfactory in use, and each is offered the reader for his choice. This work has been and will remain a standard text and reference for the treatment of fractures.—*Orville R. Clark, M.D.*

\* \* \*

*Autonomic Nervous System, The.* By Albert Kuntz, Ph.D., M.D. Published by Lea and Febiger, Philadelphia 6, Pennsylvania. Third Edition, Revised and Enlarged, 687 pages. Price \$8.50.

This standard reference book has, in its third edition, been extensively revised and partially rewritten and reorganized. It is an exhaustive survey of the autonomic nervous system, both from a general aspect and as it relates to each organ system of the body, in health and disease. It is carefully documented, but does not obsessively enter into the laboratory arguments of each controversial part. While this occasionally leads to dogmatic statements about still unsettled points, it actually enhances the value of the book for the student, general practitioner, and specialist. It is highly recommended for either reference or detailed study.—*Ruth I. Barnard, M.D.*

\* \* \*

*The Osseous System, a Handbook of Roentgen Diagnosis.* By Vincent W. Archer, M.D. Published by the Year Book Publishers, Inc., Chicago. 320 pages, 148 plates, many of which include more than one radiograph. Price \$5.50.

This little volume is one of a series of monographs on Roentgen diagnosis which has been published by the Year Book Publishers. This book is written by a capable roentgenologist, "for and . . . dedicated to the occasional radiographer." It is brief and very much to the point. Illustrations are profuse and unusually clear for such small reproductions. The practical nature of the book may be assumed from a glance at the various headings of chapters: "Technic: Principles of Interpretation: Roentgen Anatomy," "Injuries to the Skeletal System" (there is a separate chapter for the spine) "Bone Diseases and Abnormalities in Childhood," and "Bone Diseases Occurring Principally in Adult Life." The practitioner who likes to interpret his own patients' films, either in addition to or instead of the readings of the radiologist, will get much that is of practical clinical value from this little volume.—*Orville R. Clark, M.D.*

\* \* \*

## Books Received

*Penicillin—Its Practical Application.* By Sir Alexander Fleming, F.R.C.P., F.R.C.S., F.R.S. 380 pages, 59 illustrations. Price \$7.00. Published by the Blakiston Company, Philadelphia 5, Pennsylvania.



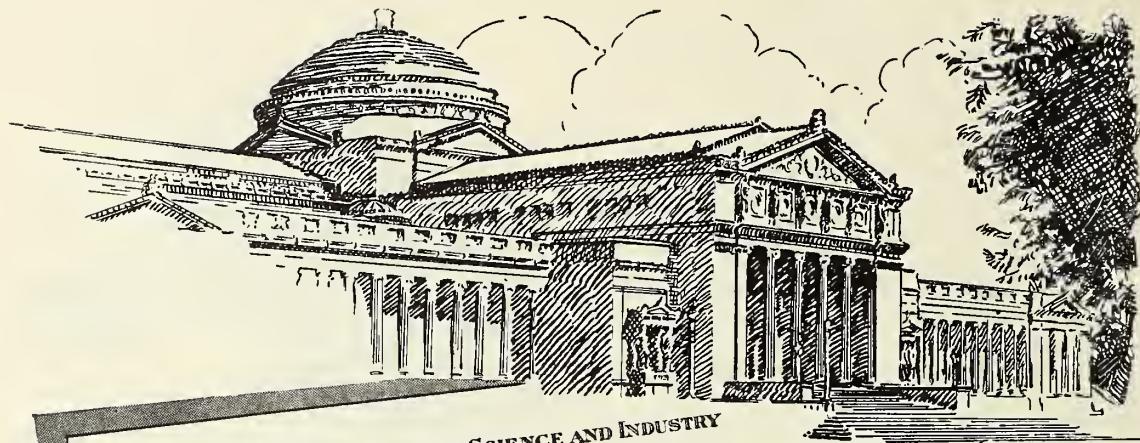
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Mr. C. H. Fleck, President  
S. H. Camp and Company,  
Jackson, Michigan

August 7, 1946

Dear Mr. Fleck:

Today marks the 10th Anniversary of the Transparent Woman exhibit and since the famous "lady" is making her permanent home in our Medical Section, we feel that the day should not be allowed to pass without some comment.

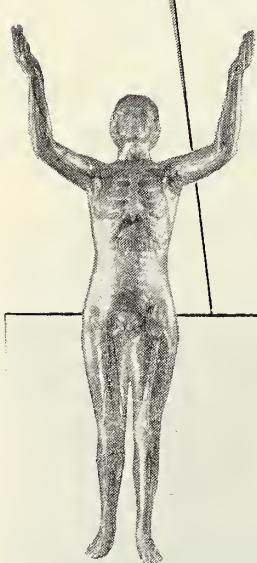
I vividly recall the premier of the Transparent Woman at Rockefeller Center in New York City before a distinguished assembly of physicians, scientists and educators. Its later tour throughout the Nation under the auspices of state and county medical societies and academies of medicine was a significant contribution to public health education. You are to be congratulated not only on your sponsorship of this important and effective exhibit but also on the ethical manner in which it was presented to the laity through the profession.

The Transparent Woman continues to be one of the major centers of interest at the museum. Practically all of the 1,026,250 visitors last year made her acquaintance and preliminary 1946 figures show the attendance running higher.

It is fitting on this 10th Anniversary of the Transparent Woman exhibit to again express our appreciation to you for your active interest in the Medical Section.

Cordially yours,

*Eben J. Carey*,  
EBEN J. CAREY, M.D., Curator,  
Medical Exhibits



CAMP TRANSPARENT WOMAN EXHIBIT MARKS TENTH ANNIVERSARY

Dedicated at Rockefeller Center in 1936 by world famous figures in medicine, science and education, the Transparent Woman has since been viewed by some 50,000 physicians and 16,000,000 laymen. Its steady pop-

ularity in the Medical Section of the Museum of Science and Industry verifies our hope that the exhibit will continue to play its authentic role in public health education within the precepts of the medical profession.

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# THE JOURNAL of the KANSAS MEDICAL SOCIETY

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Volume XLVII

OCTOBER, 1946

Number 10

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## HAZARDS IN THE UTILIZATION OF METALLIC EXTERNAL SKELETAL FIXATION IN THE TREATMENT OF FRACTURES\*

Mather Cleveland, M.D.

New York City

One of the manifestations of the machine age that has invaded the medical field is the use of various metallic gadgets devised to reduce fractures and maintain their reduction. The salesmen who demonstrate these varying apparatuses work on dry bones which have been appropriately fractured by an osteotome. The doctors at every medical convention, large or small, are shown how a few simple twists of the side arms will bring the bones out to length and by rotation the fragments will slide gracefully into position. It's a pretty sight and it's so simple that anyone can do it. So why hesitate? The investment of \$1000 or so in the necessary equipment is small compared to the boon about to be conferred on suffering humanity.

It's so plausible and so utterly simple working on that dried bone, but let's see what may happen when the dried bones have a blood supply, a periosteal envelope, are surrounded by living contracting muscles with nerves and blood vessels adjacent and an overlying skin and subcutaneous tissue. In other words, is the gadget the answer to the doctor's prayer in the treatment of fractures?

The Medical Department of the U. S. Army, through its medical supply, purchased an unknown but vast quantity of these external fixation jobs and the Hospital Corps of the U. S. Navy went off the deep end in recommending an apparatus of this sort by name. This naval recommendation found its way very promptly into one of the weekly news magazines early in the war. The follow-up studies on this critical survey are still to be published, I believe.

Some well known orthopedists prior to our entry into the war issued a report on some 60 odd patients treated by external skeletal fixation in a hospital in Britain. Later and more prolonged observation of these patients, who were still under treatment when our Army surgeons arrived, failed to corroborate the

enthusiastic report. Many of the fractures were un-united and there was a high incidence of infection.

The experience in the Army with these methods of external skeletal fixation was not a happy one. Delayed union and pin hole infection occurred in a very high percentage of the fractures so treated. Soldiers treated by these means overseas and returned to the Zone of the Interior with pins incorporated in circular plaster of paris splints, arrived with ulcers leading down to the bone,—ring sequestra resulted and often frank osteomyelitis. The pins were found extending into joints or transfixing muscles and tendons and even major peripheral nerves with resulting paralysis. Pins which transfixed muscles and tendons caused pain, preventing the patient from moving the adjacent joints, and hence defeated one of the purposes of this form of treatment, which is presumably early motion. Foot drop was not infrequently seen, due to insertion of the pin through peroneal nerve branches. One general hospital reported three fractures in which gangrene of the extremity occurred, necessitating amputation of the leg. This was due to perforation by the pin of a major blood vessel.

The complications and risks involved were so great that these gadgets were peremptorily removed from all outlying hospitals and used only in a few carefully selected cases in the large fracture centers where the expert fracture surgeons were on duty.

In the European Theatre of Operations, the only excuse for the use of this external fixation apparatus was on a severe compound fracture with large loss of bone and soft tissue. In such a case it was very occasionally employed for a period of three weeks while a pedicle skin graft was in process of growing from the donor to the recipient site. Once the graft had taken, skeletal traction in balanced suspension was used to hold the fracture.

In the treatment of simple fractures, the external metallic skeletal fixation means a continuing com-

\*Presented before the 87th annual session of the Kansas Medical Society, Wichita, Kansas, April 24, 1946.

pounding of the fracture or bone with its ever present possibility of infection. The prolonged use of the apparatus in treatment of compound fractures practically precludes the possibility of converting the fracture into a simple one by delayed primary closure of the wound.

With this preliminary survey of the set up, I should like to submit a few cases in evidence. Most of these came to our orthopaedic service at St. Luke's Hospital after they had gotten into trouble. One of them owes her trouble to us. In one instance we used the apparatus to achieve our purposes, realizing its dangers, and obtained a good result. There are two soldiers from one of our Army General Hospitals who were treated by this method.

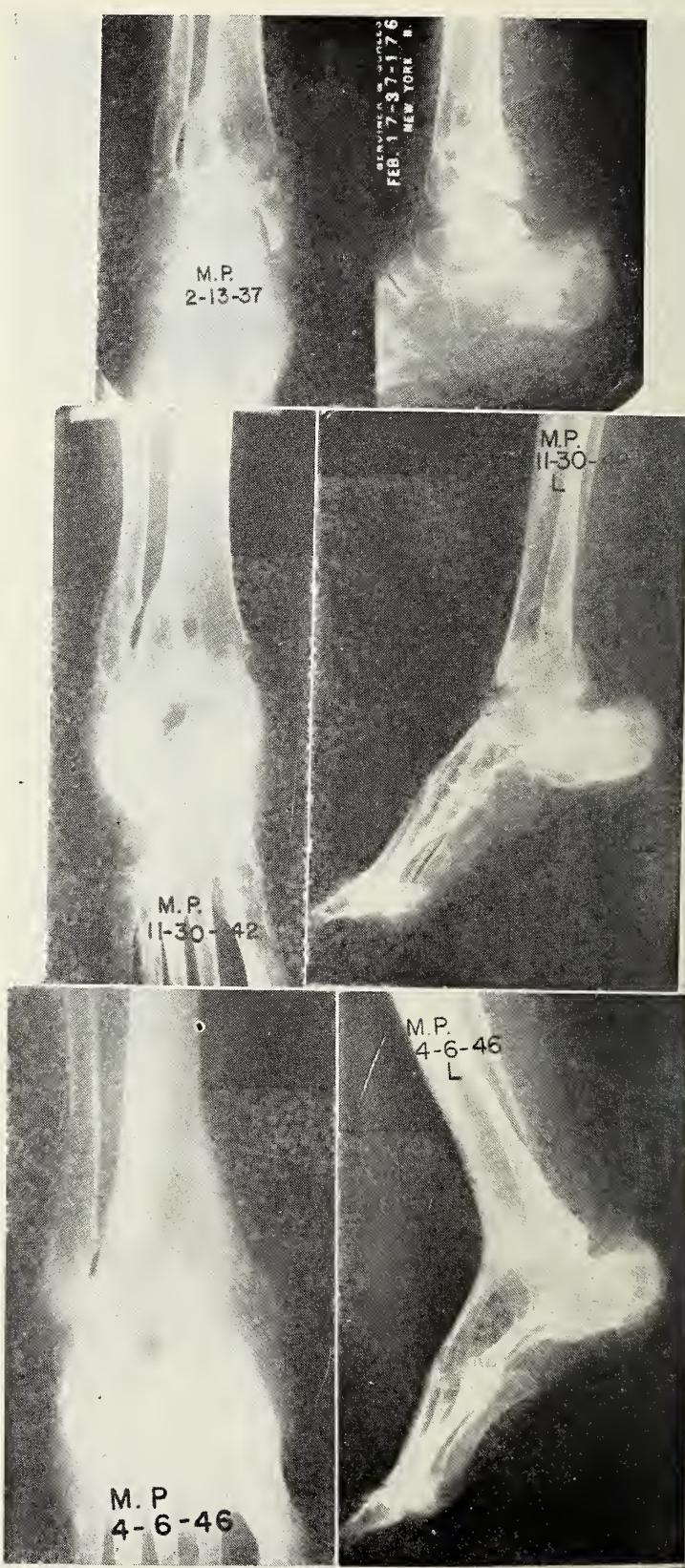
CASE No. 1. (See Figure 1). M.P., Orthopaedic Service, St. Luke's Hospital, N. Y. C. This patient sustained a fracture of the lower extremity of left tibia and fibula, medial and lateral malleoli, and posterior tibial articular surface, so called "tri-malleolar fracture," 3 February 1936. Treated at another hospital by insertion of Steinman pins through the lower end of tibia and the os calcis incorporated in plaster of paris.

One year later the patient was seen by a member of our orthopaedic service with sinuses at site of both pins, a suppurative arthritis of the talocalcaneal joint and a suppurative osteomyelitis of the os calcis. Surgical drainage was secured by two operations. The wounds did not heal until December of 1940, almost four years after the fracture was sustained. After healing, the disability was marked because of

Figure 1. A. Roentgenograms, 13 February 1937, showing an anteroposterior and lateral view of the ankle and rear foot. Pin holes are obvious in the tibia and os calcis. Destruction of the subtalar joint and definite osteomyelitis of the tibia and os calcis may be seen.

B. Roentgenograms, 30 November 1942, show surgical fusion of the ankle joint, spontaneous fusion of the subtalar and midtarsal joints. Although the process has been healed, evidence of residual osteomyelitis of the tibia and os calcis is apparent.

C. Anteroposterior and lateral roentgenograms of the foot and ankle, April 1946, showing complete obliteration of all joints of the foot and ankle—an extremely unfortunate outcome.



equinus and the gradual destruction of the ankle joint. A wedge osteotomy of the ankle joint was performed and a stable weight bearing foot with 20 to 25 degrees of equinus secured in 1942. In August of 1943, almost seven and a half years after the original fracture, this patient had healed her wounds. There was spontaneous fusion of the joints of the tarsus. There remains a crippling disability.

In this instance, a simple fracture was compounded for a long period and infected, with a disastrous result, because of external skeletal fixation inadvisedly chosen as a means of treatment and utilized by a physician who was not technically competent. The pin driven through the tibia was almost through the fracture site. The os calcis, originally intact, became the site of a destructive osteomyelitis.

The original roentgenograms are in the archives of the first hospital. I should think that an open reduction and fixation of the posterior tibial fragment with one or two screws should have resulted in healing of the fracture and return of function within four to six months.

CASE No. 2. (See Figure 2.) M.R., Orthopaedic

Service, St. Luke's Hospital, N.Y.C. This patient sustained a severe fracture at the right ankle, a so-called "tri-malleolar" type, 8 February 1945. Reduction and external fixation was attempted at another hospital by Steinman pins through the tibia and os calcis for counter traction. These were incorporated in plaster. This method failed to secure reduction of the posterior tibial articular surface. Twelve days later the patient was seen by a member of our staff and he decided to gamble on getting a good ankle joint by changing the type of fixation. The pins were withdrawn. There was no apparent infection and an open reduction was performed with internal fixation of lateral malleolus and posterior tibial lip by vitallium screws. One year later the patient has a perfect ankle with fractures healed eight to ten weeks after the operation.

In this instance external skeletal fixation was poorly chosen and failed to secure reduction. The prompt shift to internal fixation averted a certain painful ankle with limited motion and the possibility of infection through prolonged compounding. Such a shift in treatment has its dangers and the situation

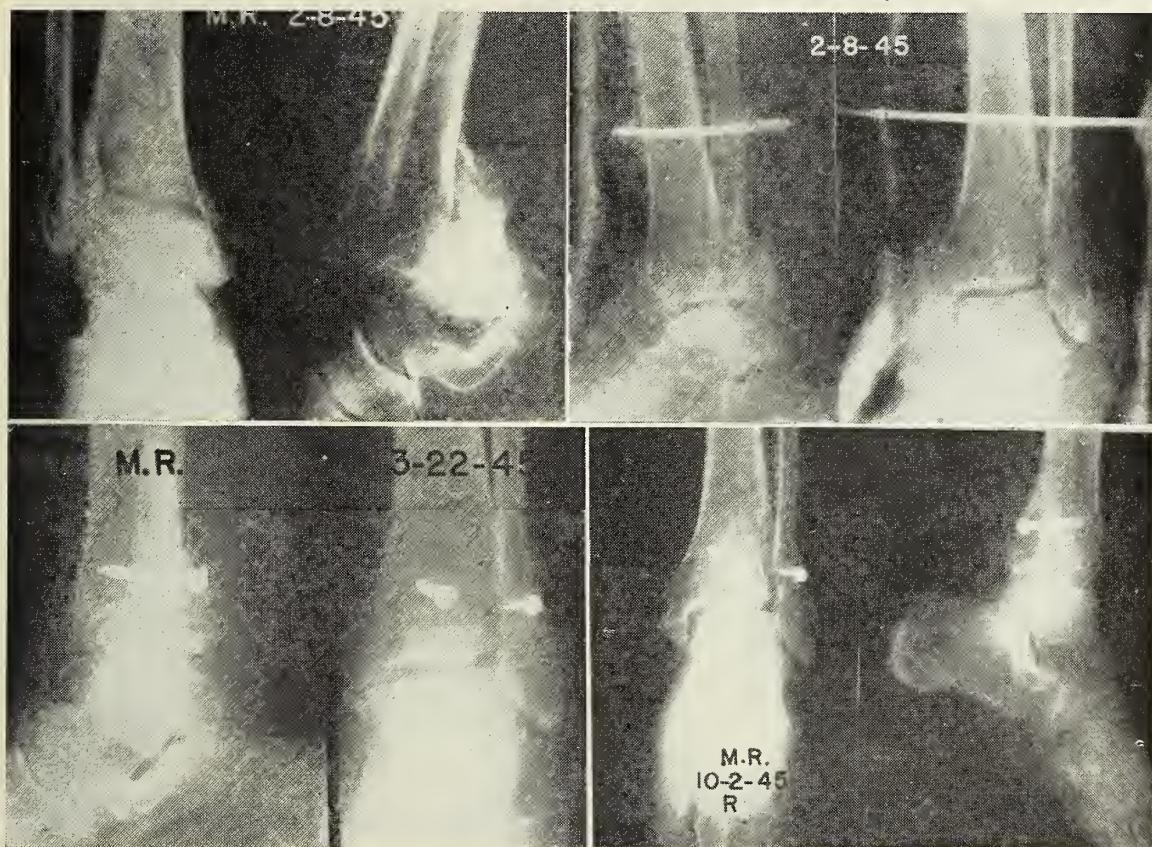


Figure 2. A. Anteroposterior and lateral roentgenograms of the right ankle showing the original fracture with marked displacement, 28 February 1945.

B. Anteroposterior and lateral roentgenograms of the right ankle, 28 February 1945, showing reduction obtained by pins inserted in the tibia and os calcis. The lateral view reveals the posterior tibial fragment still displaced upward un-reduced.

C. Anteroposterior and lateral roentgenograms of the same ankle, 22 March 1945, one month after open reduction and fixation with vitallium screws. Reduction is complete.

D. Anteroposterior and lateral roentgenograms of the ankle 2 October 1945, seven and one-half months after open reduction and internal fixation. Fracture entirely healed. A complete and perfect restoration of the ankle joint.

would have been much less complicated had the external skeletal fixation not been employed.

CASE No. 3. (See Figure 3.) M.O., Orthopaedic Service, St. Luke's Hospital, N.Y.C. February 1943. Admitted one month after injury. This patient sustained a fracture of both calcanei. An external fixation apparatus was applied to each with a pin driven through each os calcis and the tibia above for counter traction. This was performed at another hospital. The pin holes on the right leg all showed evidence

of suppuration one month later. The tibial pin holes on the left leg at this time showed granulation tissue but no frank suppuration, and these healed uneventfully with wet dressings after removal of the pins. The right foot was seriously infected with a suppurative arthritis of the talocalcaneal and ankle joints, requiring incision and drainage and application of plaster of paris circular splint. The wounds healed seven months later.

The end result in this case, two years after injury,

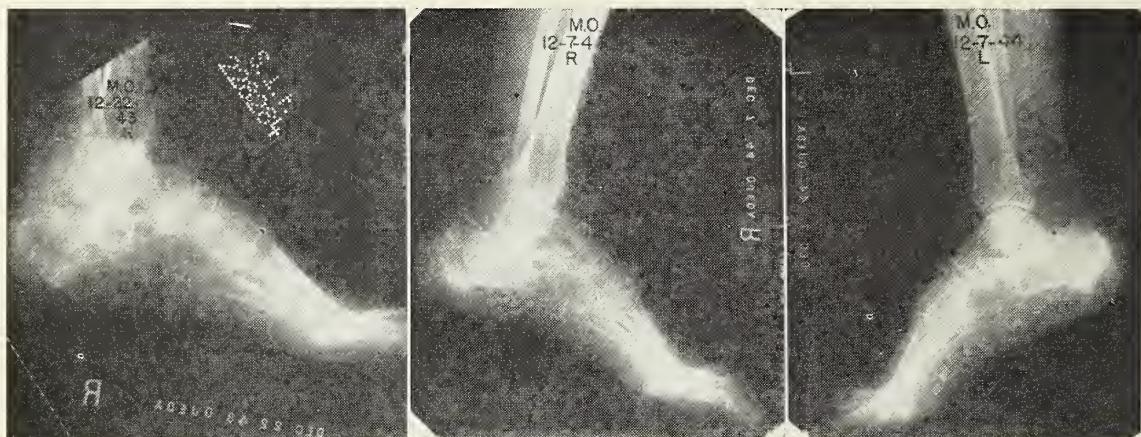


Figure 3. A. Lateral roentgenogram, 22 December 1943, of the right foot after wounds had healed. Pin hole through the os calcis is plainly visible. Profound atrophy of all bones of tarsus is obvious. The ankle and subtalar joints show erosion of cartilage. The os calcis shows healing osteomyelitis.

B. Lateral roentgenograms of right foot, 7 December 1944, almost two years after the injury. Destruction of ankle and subtalar joints is even more obvious. The disuse atrophy has cleared up.

C. Lateral roentgenogram of the left foot, 7 December 1944, two years after injury, showing a slightly flattened os calcis, all joints of tarsus and ankle are normal. The foot narrowly escaped the fate of the right foot.

Had the pins been left in another week or ten days, there would probably have been a situation similar to that encountered on the right foot.

The original roentgenograms which are the property of the surgeon who inserted the pins are not available for this presentation.

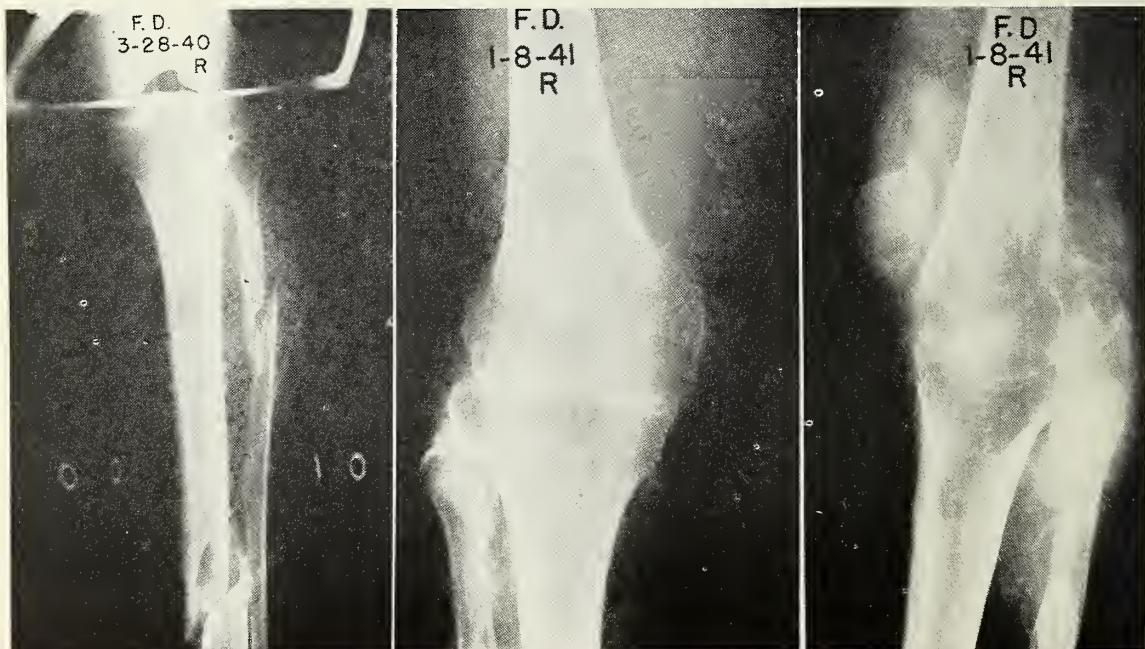


Figure 4. A. Roentgenogram of a fracture of tibia and fibula, 28 March 1940, with a Steinmann pin traversing the knee joint. B. Anteroposterior and lateral roentgenographic views of the spontaneous fusion of this knee joint, 8 January 1941, ten months later. It should be noted that the fibular fracture is healed.

is a painful right foot with disability, due to complete loss of motion at ankle and tarsal joints.

This was a simple fracture compounded and infected by use of external skeletal fixation—an avoidable surgical disaster. Neither of these fractures was originally serious enough to warrant such treatment. Fractures of the os calcis with minimal displacement do extremely well with bed rest without fixation. If there is residual pain after healing, due to changes in the subtalar joint, a subtalar arthrodesis should be performed.

CASE No. 4. (See Figure 4.) F.D., Orthopaedic Service, St. Luke's Hospital, N.Y.C. This patient represents as bizarre an application of the use of extra-skeletal traction and fixation as one could hope to see. In March of 1940 he sustained a fracture of the tibia and fibula of the spiral type. At another hospital one Steinman pin was placed in the os calcis and a second one through the upper tibia, supposedly, but actually it was driven through the knee joint by a thoroughly incompetent physician who had no training in bone and joint surgery. As a result of this malpractice, there developed a staphylococcus suppurative arthritis of the knee joint. The patient became very ill with 105 degrees of temperature. A member of our orthopaedic service was called after the damage was done. Incision and drainage and removal of the pin was performed and the knee joint progressed to solid bony ankylosis.

Six years later this patient is still having an oc-

casional flare-up with an abscess to be drained.

This is a flagrant example of a potentially dangerous procedure utilized by an ignoramus, with disaster to the patient. This is a heavy price for any patient to pay.

Five years later patient was seen for incision and drainage of an abscess at the knee.

CASE No. 5. (See Figure 5.) E.M., Orthopaedic Service, St. Luke's Hospital, N.Y.C. Automobile accident 1930. Patient sustained a badly comminuted displaced fracture of left femur, 11 October 1930. Approximately three weeks later, external skeletal fixation was applied by two Steinman pins through the fracture site and two through the upper shaft of the femur, incorporated into two side arms. The fracture was reduced and in fact distracted. Osteomyelitis developed. Three operations were performed to remove sequestra and improve drainage. This fracture healed with malunion and a stiff knee.

The patient is rated as a total disability by the insurance company which was liable for this claim. She was under treatment for six years. Had she been treated by skeletal traction through the upper tibia or by Russell traction, a far better result would certainly have been achieved.

This is an illustration of a poor choice of treatment. External skeletal fixation was employed in a fracture which did not lend itself to that form of treatment. Steinman pins which traverse the fracture site invite infection in the devitalized tissue. The

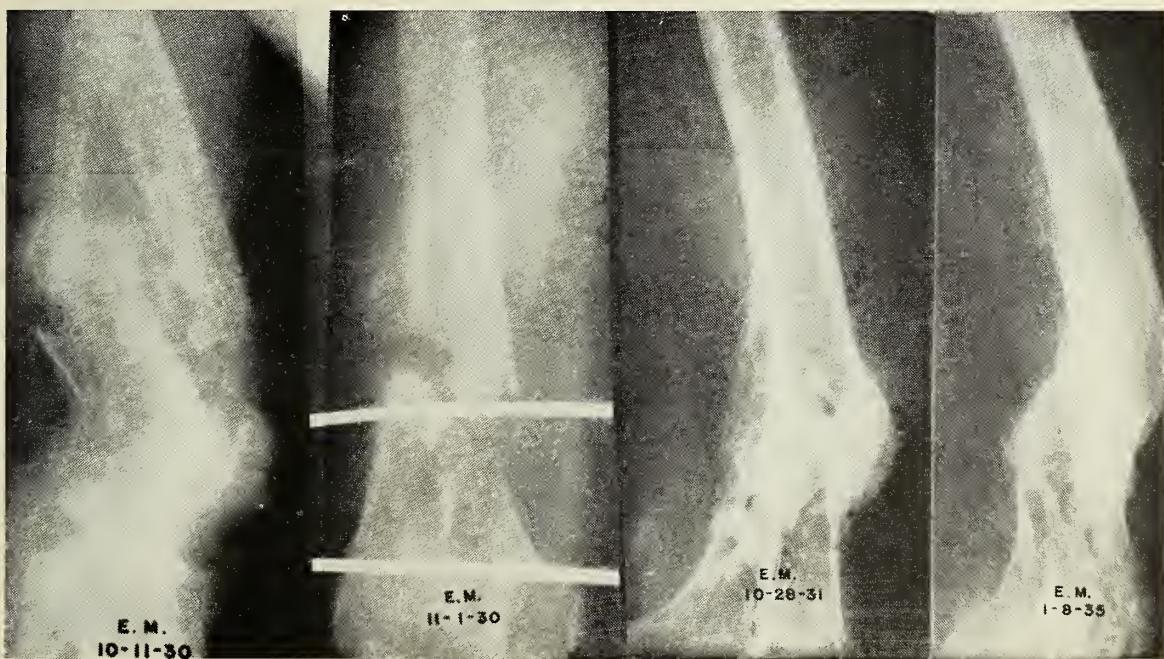


Figure 5. A. Roentgenogram, 11 October 1930, shows a lateral view of fracture of femur with marked comminution and displacement. B. Roentgenogram, 1 November 1930, with fracture reduced and maintained by external skeletal fixation—three weeks later. C. Roentgenogram, 28 October 1931, one year later, showing abundant callus. Pin holes still visible. Several obvious sequesters may be seen. D. Roentgenogram, 8 January 1935, four and one-half years after injury. Femur healed and united with malunion obvious. The stiff knee joint does not show.

surgeon who treated this patient has long since abandoned the use of external metallic skeletal fixation in the treatment of fractures.

CASE No. 6. (See Figure 6.) T.C., Orthopaedic Service, St. Luke's Hospital, N.Y.C., 1936. This patient sustained a simple fracture of the right femur and a severely comminuted fracture of the right tibia extending into the knee joint—a coasting accident. This was treated by a Steinman pin and traction through the lower tibia. A dry gangrene of the leg below the knee developed and the patient and his family blamed this on the treatment used in this case.

The leg had to be amputated at the knee and a Gritti Stokes amputation was performed. Pathological examination revealed that the anterior and posterior tibial vessels were divided by the original injury.

This is an instance in which the pin fixation was unjustly blamed for a situation in which irreparable damage had been done to the main blood vessels. The surgeon here had to be extricated by the pathologist from a situation into which he placed himself by driving a pin through the lower tibia. The loss of the leg was inevitable following the injury sustained to the blood vessels.

CASE No. 7. (See Figure 7.) A.S., Orthopaedic Service, St. Luke's Hospital, N.Y.C. At seven years of age, on 1 March 1934, the patient was struck on right leg by a box thrown from a truck. He sus-

tained a serious fracture at the ankle with displacement through the tibial epiphyseal line. There was a fracture of the fibula above the malleolus. A closed reduction secured adequate re-position of the fragments. The patient was discharged from hospital two days later in a plaster boot.

The second admission to hospital on 25 January 1940 showed three-fourths inch shortening of right tibia with varus deformity of the foot. Patient was then 13 years of age.

Since there was a medial bowing of the tibia and an obvious overgrowth of the lower fibular epiphysis and none at the lower tibial epiphysis, a wedge osteotomy was performed and a bone graft was inserted into the divided tibia to swing it into proper position. A plaster of paris circular splint was applied from toes to groin. This operation failed utterly. The deformity recurred.

The patient was re-admitted March 1941. Two Steinman pins were inserted below the deformity and two above in the tibia. The tibia was divided and pulled out to length, correcting the deformity. Chips from the ilium were inserted into the defect. Plaster of paris splint was applied over the pins. In three to four months an infection was noted. The tibia was pulled to length and united, *but* ring sequestra had developed.

27 December 1941—sequestrectomy was performed.

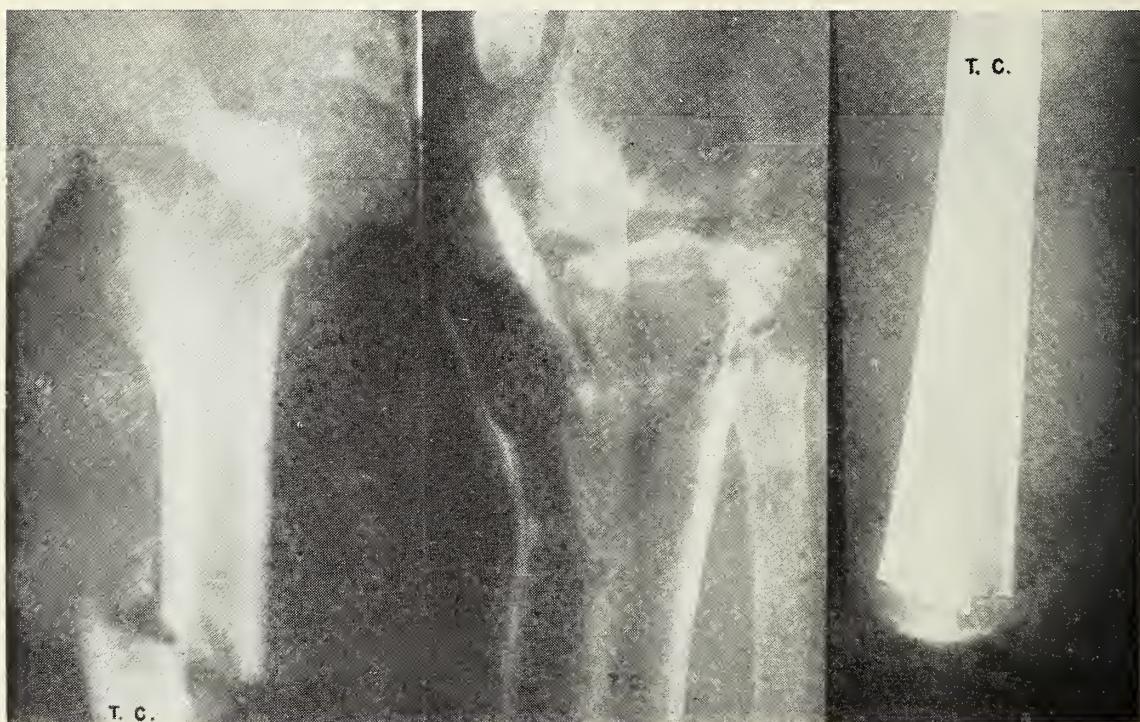


Figure 6. A. Anteroposterior roentgenogram of the right femur showing a fracture of the junction of upper and middle third. B. Anteroposterior roentgenogram of the right leg shows knee joint and severely comminuted fracture of the tibia entering the joint. C. Roentgenogram showing an anteroposterior view of the Gritti Stokes amputation stump. No fixation was utilized on this other than a firm bandage. An excellent end bearing stump was secured.

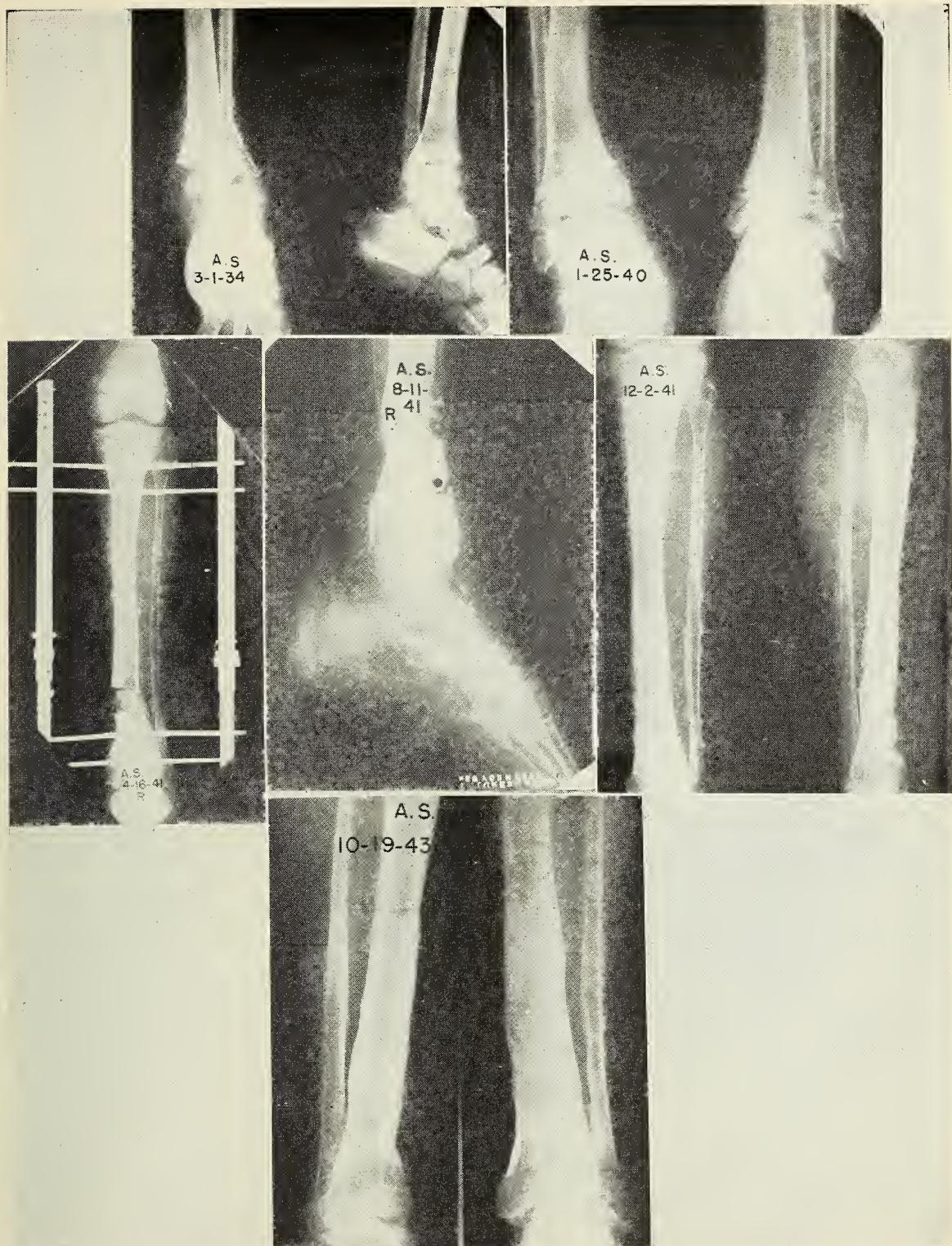


Figure 7. A. Anteroposterior and lateral roentgenograms of right ankle, 1 March 1934, showing fracture of shaft of fibula and tibia extending across the tibial epiphyseal plate.  
 B. Anteroposterior roentgenograms of ankle, 25 January 1940, six years later, showing arrest of growth to right tibial epiphysis with varus deformity due to persisting growth of the fibular epiphysis. The contrast with the normal ankle joint shows this obvious difference.  
 C. Anteroposterior roentgenogram, 16 April 1941, of the ankle joint and tibia with external skeletal fixation and correction of deformity by osteotomy and insertion of iliac bone chips. Two pins through the tibial shaft above and two below the osteotomy site.  
 D. A lateral roentgenogram, 11 August 1941, shows the healed osteotomy with ring sequestrectomy in both the two lower tibial pin holes.  
 E. Anteroposterior roentgenograms, 2 December 1941, of the right tibia and fibula following sequestrectomy, showing healing of the osteotomy and also of the osteomyelitis.  
 F. Anteroposterior and lateral roentgenograms, 19 October 1943, of tibia and fibula and ankle joint, showing complete healing of osteotomy and osteomyelitis with correction of deformity. Eight and one-half years after the injury.

February 1944—excision of scar and pedicle graft from the calf of opposite leg.

Correction of deformity was achieved—osteomyelitis resulted, necessitating sequestrectomy and pedicle skin graft. Final result is excellent.

This is shown as an illustration of the use of extra-skeletal fixation where it is necessary to correct deformity and secure lengthening of bone. It also shows the hazards of osteomyelitis which necessitated additional operative treatment, a perfect example of ring sequestrum due to torsion, traction and the trauma of drilling the bone.

CASE No. 8. (See Figure 8.) T/Sgt. J. S. Jeep accident 21 May 1945. Fracture of left femur, comminuted, compound. Fracture of right femur, simple. Peroneal palsy. Bilateral plaster of paris spica was applied. Removed at another hospital 2 June with transfusions and dressing of wounds. Arrived at a west coast Army General Hospital 24 June. Severe posterior angulation of both fractures. Skeletal traction was applied, utilizing 20 to 25 pounds weight. Left femur showed improved position, but right did not. The patient developed haematuria with pain in right flank, then symptoms suggesting gall bladder. He was placed in hip spica for transfer to an eastern Army General Hospital and was admitted there 5 August 1945. Wound on left thigh draining profusely. No evidence of union of left femur. Right thigh also showed a granulating wound with no evidence of union of the fractured femur. Skeletal traction in balanced suspension was reinstated. The left femur was readily reduced once more, but the right femur was unaffected, so an apparatus for external skeletal fixation and reduction was applied, utilizing three screws in the distal and three in the proximal fragment. Satisfactory reduction of the fracture was obtained. An abscess of left thigh was drained 28 August. Penicillin was administered during the patient's entire hospital stay.

The external skeletal fixation apparatus was removed 26 October and patient was transferred to another Army General Hospital because the hospital at which he was being treated was closing. For this transfer a bilateral plaster of paris spica was employed. At this final hospital both fractures were found to be infected and drained profusely. The right showed profuse drainage from all the sinuses which marked the sites of insertion of the screws. Healing has progressed very slowly, but it is taking place.

This patient with one compound fracture of the femur, had the second femur compounded and infected by the use of an external skeletal fixation apparatus. He should have done infinitely better had he been promptly placed in skeletal traction with balanced suspension and not evacuated so far and

so frequently until some union of these fractures had taken place.

CASE No. 9. (See Figure 9.) J.L., Captain. Patient sustained a simple spiral fracture of the shaft of the right humerus while playing baseball, 20 July 1942. He was admitted to nearby Army General Hospital, where metallic external skeletal fixation was employed to reduce and maintain reduction of the fracture. On inserting the pins through the distal fragment, difficulty was experienced in the insertion of the second pin, which was found later to impinge upon the first pin in the distal fragment. Although this fracture healed without symptoms, the roentgenograms showed progressive aseptic necrosis in and around the two distal pin holes. This aseptic necrosis was thought to have been due either to electrolytic action of the metals or to the heat caused by the friction of the contacting pin points at the time of insertion. This is an illustration of aseptic necrosis which failed to develop infection because the pins were removed within eight weeks. This is not usually the situation in the lower extremity and infection is more apt to intervene because of the much longer period of time during which the pins are employed. This fracture would originally have been much more easily treated by an open reduction and the insertion of one or two vitallium screws across the fracture line.

#### COMMENTS

A series of nine patients has been presented to show some of the complications which must be expected if external skeletal fixation is employed in the treatment of fractures. Infection is chiefly to be feared and six of these patients had osteomyelitis, suppurative arthritis, or ring sequestra. The prolonged suppuration for six years in two patients and seven and a half years in another, makes this particular complication one to be dreaded by the doctor and the patient alike.

The various types of external skeletal fixation are by no means simple to apply, nor should they be in the hands of any but the most experienced fracture surgeons. The pin thrust through the knee joint is evidence of forgotten anatomy and an attempt to substitute a gadget for brains.

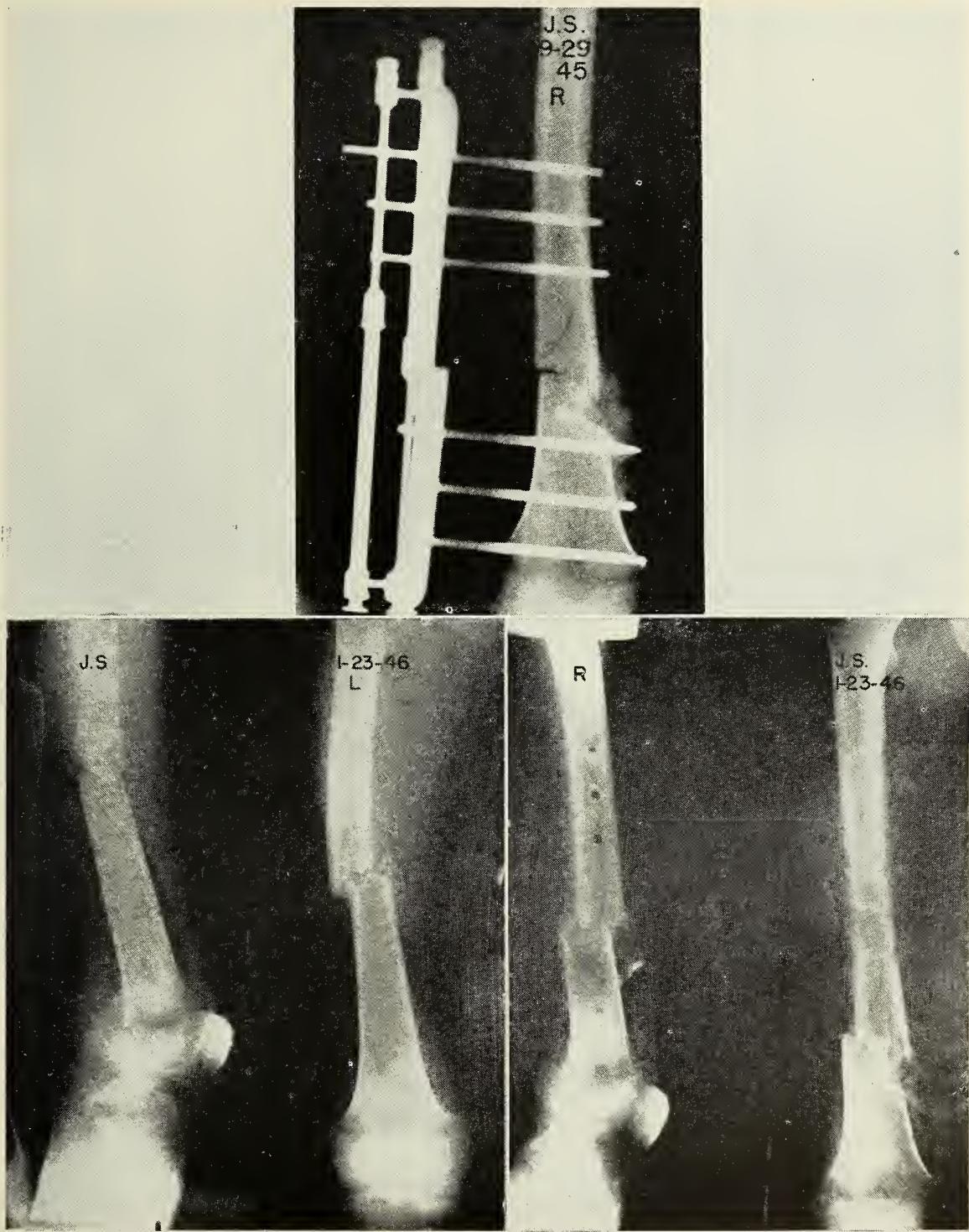
Most of the bone and joint surgeons who have tried this method of fixation of fractures have discarded it because of the complications I have shown. These have occurred when the treatment was in the hands of competent men. When these gadgets are utilized by surgeons with less training, the incidence of complications rises sharply. This was seen in our Army Medical Corps to such an extent that the use of these external skeletal fixation apparatuses was prohibited in all but a few special instances.

A simple fracture, if adequately reduced, will heal

better and with less chance of complications than will a compound fracture.

I have shown five simple fractures which have

been compounded by the surgeon for varying periods of time with resulting infection. Four of these led to disastrous results and the fifth is not yet healed.



**Figure 8. A.** Anteroposterior roentgenogram, 29 September 1945, of right femur with the external skeletal fixation apparatus in place. The fracture is definitely reduced.

**B.** Anteroposterior and lateral roentgenograms, 23 January 1946, of the left femur, eight months after injury. Position is fair. Callus is not abundant.

**C.** Anteroposterior and lateral roentgenograms, 23 January 1946, of the right femur after removal of the apparatus. This is eight months after injury. The screw holes are very evident.

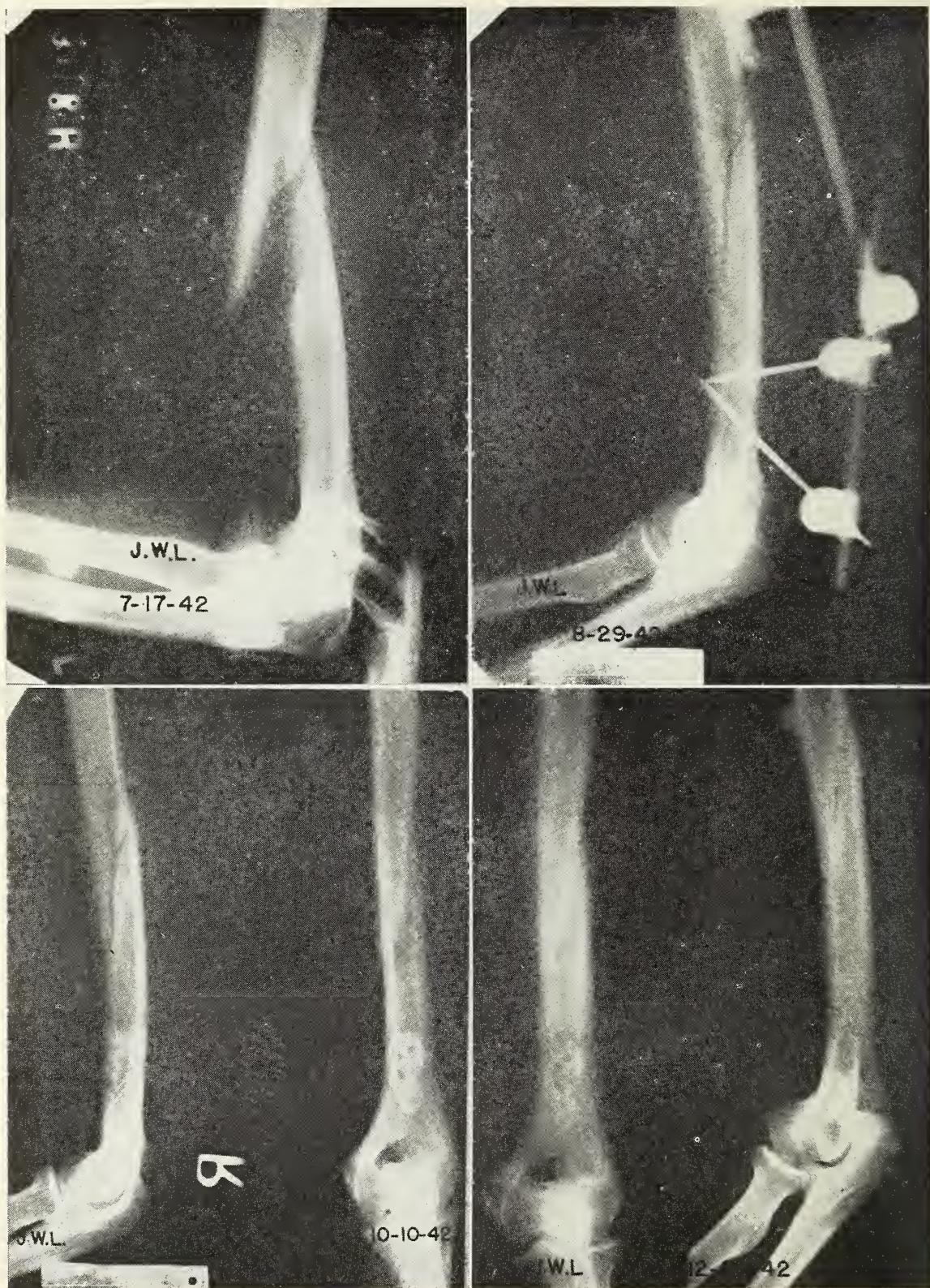


Figure 9. A. Raentgenogram, 17 July 1942, showing lateral view of the fracture.

B. Raentgenogram, 29 August 1942, showing fracture reduced with the external fixation apparatus and the pins in the lower fragment readily visible. Six weeks after injury.

C. Raentgenograms, 10 October 1942, anteraposterior and lateral view of the humerus showing the fracture healed with the pin holes readily visible and dense sclerosis of bones surrounding them. Almost four months after injury.

D. Final raentgenogram, 2 December 1942. Anteraposterior and lateral views of the shaft of the humerus show fracture solidly healed. A little under six months after injury with the aseptic necrotic changes still visible in the distal fragment.

## PANCREATIC LITHIASIS

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Published cases of pancreatic lithiasis are slowly increasing in number. Approximately 220 have been reported since de Graaf's original description of this disease in 1667. We add the following to this growing list:

C.W., a 36-year-old white male, was first admitted to the University of Kansas Hospitals in July, 1944 complaining of recurrent attacks of abdominal pain and diabetes. He stated that he was last perfectly well eight years prior to admission. At this time, following a three-day drunk, he became ill with nausea, vomiting and severe epigastric pain. Later the pain became localized in the right lower quadrant of his abdomen. An appendectomy was done the following day. He stated that his surgeon told him he had a ruptured appendix. His convalescence was uneventful. He got along fairly well then until two years later when he began having recurrent attacks of severe, sharp, epigastric pain which radiated through to his back. These attacks came on about five minutes after meals, lasted about 30 minutes, and were accompanied by nausea and vomiting. The vomiting frequently relieved the severe pain. The vomitus contained partially digested food and bile. There was no hematemesis or melena. There was no food dyscrasia. On three occasions he passed very foul-smelling, light-colored, fatty stools. He stated that he had two or three such attacks over a period of three or four days and then would be quite well again for several weeks or months.

About four years after the onset of his illness, the patient developed a more severe attack of abdominal pain, accompanied by constipation, severe protracted vomiting, and abdominal distention. He was not relieved by gastric suction; therefore, an exploratory laparotomy was done. This, he was told revealed obstruction of the small intestine due to adhesions.

During the following two years he developed the typical symptoms of diabetes mellitus. This diagnosis was proved by laboratory examination.

One month prior to his admission here, his attacks of pain became more severe and also more frequent so that during that month he had from three to four attacks every day, some of which required morphine for relief. There was no jaundice or fatty stools at this time.

Past history revealed that he had the usual childhood diseases without complications. He had quinsy

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once and had several broken bones—all bones were broken by severe trauma.

The symptom review added nothing except that he was a heavy smoker and that he used alcohol excessively. Many of his attacks of pain were precipitated by alcoholic sprees.

There was no family history of diabetes mellitus.

Physical examination showed a well developed, well nourished white male of the stated age. Eyes, ears and nose were normal. The mouth showed high grade oral sepsis and dental caries. The tonsils were small and equal in size. The anterior tonsilar pillars were injected. There was bilateral anterior cervical lymphadenopathy. The thyroid was normal to palpation. Both lung fields were clear to auscultation and percussion. The heart was not enlarged and no murmurs were heard. The blood pressure was 120/80. There was tenderness to deep palpation in the epigastrium. Carnett's sign was negative. There were no masses and no rigidity. A healed right lateral rectus surgical incision was present. The extremities were normal except for slight deformity due to the old healed fractures. The reflexes were physiological.

Laboratory examination showed normal urine except for small amounts of sugar in some specimens. The red blood count was 4,720,000, hemoglobin 90 per cent, white blood count 12,900, and the differential count was normal. Blood chemistry was as follows: Cholesterol 307 mg. per cent, N.P.N. 23 mg. per cent, serum amylase 98 mg. per cent, blood sugars varied from 111 mg. fasting to 222 mg. per cent postprandial. Gastric analysis showed hypochridercity.

X-ray examination of the gastro-intestinal tract showed a moderate pylorospasm and irritability but no deformity of the duodenum. No segmentation was seen in the small intestine. The colon was normal.

At the time of this examination the X-ray showed numerous small opacities in the upper mid abdomen. Subsequent films localized these two to three cm. anterior to the twelfth dorsal and first lumbar vertebrae. The calcified deposits were irregular in outline, multiple and formed a cast of the entire pancreas. No other X-ray or laboratory examinations were done at this admission.

He was dismissed on a 125-75-75 diet and 30 units of protamine zinc insulin.

In December 1945, the patient returned to this hospital. During the interval he had been fairly well. His teeth has been removed and he had had another

exploratory laporotomy for symptoms of intestinal obstruction. His doctor told him that his pancreas was "stony hard" and that he had many intestinal adhesions.

Physical examination at this time showed no marked change over that done previously.

Laboratory examination was as follows: Urine, normal except for finding sugar occasionally; Rbc. 3,810,000, Wbc. 15,600, hemoglobin 75 per cent, differential count normal; serology negative; blood cholesterol 236 mg. per cent, calcium 12.5 mg. per cent, phosphorus 5.6 mg. per cent, N.P.N. 25 mg. per cent, creatinine 1.2 mg. per cent, serum amylase 48 mg. per cent; stool fat determination—19.3 per cent weight of total fat, 6.3 per cent weight of free fatty acid, 6.1 per cent weight of neutral fat, 6.9 per cent weight of soap fat; gastric analysis normal; blood sedimentation rate 10 mm. in one hour by the Cutler method. X-ray examination showed some increase in the number of stones in the head of the pancreas; the gastro-intestinal series and gall bladder visualization were normal.

The patient's diet was increased to carbohydrates 200, fats 70, proteins 65. With this, it was necessary to increase his insulin to PZ 10-0-0 and crystalline 30-0-0. This indicated that there was no marked increase in the severity of his diabetes.

The pictures below are reprints from the X-ray plates taken on this patient.

#### DISCUSSION OF THIS DISEASE

The deposition of calcareous material in the pancreas is now recognized as one of the causes of acute or chronic abdominal pain and diabetes mellitus. Therefore, the ante-mortem diagnosis of this condition becomes much more important than formerly thought.

The etiology of this disease is not known. Several

theories have been advanced, none of which is entirely satisfactory. Two facts stand out: first, pancreatic stones are composed largely of tri-basic calcium phosphate and calcium carbonate with smaller amounts of organic tissue debris. Normal pancreatic juices do not contain calcium. It is known that many patients, like our patient, have repeated attacks of acute pancreatitis before calcium deposits are visible on an X-ray film. Therefore, it is postulated that through recurrent inflammatory reactions in the pancreas, the chemical composition of pancreatic secretions is altered and calcium deposits subsequently appear in the ducts and pancreatic parenchyma.

Other theories are (1) regurgitation of bile into the pancreatic ducts, (2) metaplasia of the epithelium of the ducts with resulting obstruction and pancreatitis, (3) desquamated, cornified epithelium producing nidus for stone formation. Chronic alcoholism occurs in a very high percentage of patients with this disease.

The pathogenesis of the disease is thought to be that of repeated attacks of varying severity of acute pancreatitis resulting in interacinar and interstitial fibrosis and the formation of stones in the pancreatic ducts. These stones then obstruct the ducts, resulting in dilation and thickening of the duct walls with atrophy of the acinar tissue. Then, as the disease progresses further, the islets of Langerhans are affected and diabetes results. The time required for calcareous change is not known.

The true incidence of the disease is undetermined. Undoubtedly many cases have been overlooked in the past. Only 100 cases were reported from 1667 to 1925. Since then at least 120 additional cases have been reported, indicating not an increase in the incidence of the disease but a more careful search for the



disease. There is no race predilection. Men are affected more frequently than women, in a ratio of two to one. The age incidence varies from six years to 72 years, with an average age of 43 years in 26 cases reviewed.

The clinical picture varies somewhat, yet the case reported here is quite typical. Pain is the outstanding and most constant finding; it occurs in 60 to 70 per cent of all patients with this disease. It is of two types. Severe coliky pains simulating renal or gall bladder colic is the most common. It often has a direct relationship to overindulgence in food, particularly fatty foods and alcohol. It is not accompanied by fever, abdominal muscular rigidity or abdominal tenderness as is the pain due to pancreatitis, unless it persists, in which event pancreatitis is associated with the colic. Vomiting may occur. The other type of pain is that due to acute pancreatitis. Many patients have recurrent attacks of acute pancreatitis before stones are visible on the X-ray film. The coliky pain is usually epigastric in location and tends to radiate to the left and through to the back.

Fatty diarrhea is very common, as is creatorrhea. Over 50 per cent of the patients show this finding sometime during the course of the disease. It does not bear any particular relationship to the severity of the disease but depends on the location of the calcareous deposits. If these are in the large ducts and of sufficient size to cause complete obstruction, then steatorrhea results. Later as the stone is passed or edema of the duct disappears so that pancreatic juices again reach the gut, the stools become normal. Fatty diarrhea occurs commonly after bouts of colic. With complete destruction of acinar tissue or complete and permanent obstruction of the ducts of Wirsung and Santorini, steatorrhea and creatorrhea become constant and permanent, thus simulating sprue.

Diabetes mellitus occurs in about 50 per cent of these patients. At least three per cent of the pancreases of diabetics examined at autopsy show stones. Weight loss occurs very commonly.

Motor disturbances of the stomach and small intestine occur frequently. They may be of the hypo or hypermotility type, sometimes simulating peptic ulcer. Repeated attacks of nausea and vomiting are not uncommon. Secretory disturbances may occur as a result of disturbances of gastric motility. The motor disturbances of the G.I. tract are probably due to a nerve reflex mechanism.

Hepatic enlargement is present occasionally. It is thought to be due to involvement of the islet tissue with diminution in lipocaic secretion and fatty degeneration of the liver.

Ascites, edema and jaundice occur but these are uncommon. The latter may be due to a small stone

passing into the common bile duct and producing transitory obstruction at the sphincter of Oddi.

Stones have eroded into the duodenum, producing duodenal hemorrhage with fatal result. Stones have also been passed in the stool.

Infections, particularly tuberculosis, frequently complicate the disease.

The laboratory findings vary greatly from patient to patient and from time to time. Elevated blood sugars and diabetic glucose tolerance curves are seen in those who develop diabetes. Increased serum amylase and lipase occur in acute pancreatitis. A decrease in pancreatic enzymes occurs with obstruction of the large pancreatic ducts. Increased fat and protein in the stools run parallel with the decrease in pancreatic juices.

The typical and pathognomonic finding in the disease is the demonstration of calcareous deposits in the pancreas. This is best done by X-ray. Anterior-posterior and lateral views should be made of this region of the abdomen. The stones are usually dense, sharply outlined, multiple, and are grouped on both sides of the vertebral column. They are usually confined to an area bounded above by the upper level of the first lumbar or twelfth dorsal vertebrae and below by the lower border of the third lumbar vertebra. In the lateral projection they lie 2-3 cm. anterior to the spine. A duodenal tube in place helps locate the stones more accurately.

Four types of stones have been described by Gillies. They are (1) multiple irregular calculi (most common), (2) single calculi (rare), (3) multiple faceted stones resembling gall stones, (4) large fragmented stones which form a virtual cast of the pancreas.

The diagnosis then depends primarily upon the history and the X-ray findings. The latter obviously is the most important. Surgical exploration is not needed to verify the diagnosis.

The differential diagnosis is not difficult. Clinically one should think of this disease in any patient who gives a history of recurrent or chronic upper abdominal pain, particularly if that pain is just to the left of the midline and associated with diabetes. The pain does not often localize in the right upper abdomen or radiate to the right scapula as does pain due to gall-bladder disease. The pain does not radiate into the lower abdomen or genitalia as in renal colic. The lack of food relief and alkali relief are points against peptic ulcer. These do not help in differentiating pylorospasm. Sprue need hardly be considered in the differential diagnosis, since pain, diabetes and pancreatic lithiasis do not occur in this disease.

Roentgenological examination affords the best means of study. As stated, anterior-posterior and lateral views should be taken. Gallbladder visualization should be done to exclude gallbladder disease and

cholelithiasis, particularly when the stones are of the multiple facet-shaped type.

Intravenous pyelograms will help to rule out calcification in a horseshoe kidney. Usually a flat K.U.B. plate will visualize the kidneys satisfactorily.

Calcified abdominal lymph nodes are usually paravertebral in location, tend to be larger, and occasionally form a longitudinal chain along the course of the ureters. A solitary calcified lymph node high in the mid-abdomen may cause a real problem in differential diagnosis.

Calcification in the splenic artery does not cause any great difficulty in diagnosis. The splenic artery lies obliquely, high in the upper left abdomen. This is not the anatomical location of the pancreas. The calcification has the appearance of a tortuous tube. The phenomenon occurs in older individuals.

Calcification in the abdominal aorta need hardly be mentioned. This occurs as small irregular plaques located longitudinally over the vertebral bodies and usually runs the entire course of the abdomen and chest. A duodenal tube in place will often help to accurately localize the anatomical position of the calcareous material in the upper abdomen.

The gastrointestinal tract should be examined for disturbances in acid secretion and motility.

Occasionally pancreatic cysts occur as part of the disease. When present they often produce distortions of position and shape of the stomach and duodenum. One should be certain that the gastrointestinal tract is free of barium when making studies of the pancreas itself.

The therapy is not obvious. The diabetes should

be treated in the usual manner. Focal infection should be eliminated and if the patient is an alcoholic, this should be corrected. The administration of lipocaine with choline and Brewer's yeast are indicated if definite liver degeneration is present.

Many patients have had various procedures performed on them with varying results. Removal of a single or multiple stones confined to a small part of the pancreas is advisable if the patient is having symptoms that warrant surgical interference. Such symptoms are severe intractable pain, recurrent attacks of pancreatitis, or obstruction of the large pancreatic ducts with steatorrhea. Surgical interference is not warranted unless the patient is having the above symptoms or unless steatorrhea is present and the surgeon can remove stones from the large ducts.

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## PRE- AND POST-OPERATIVE PARENTERAL THERAPY

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In the last few years there have been many contributions to our knowledge of pre- and post-operative parenteral therapy. The new solutions available, and the revived interest in post-operative salt intolerance warrant a review of this subject. An attempt will be made to consider these new solutions, and to explain the concept of post-operative salt intolerance. We also wish to review and simplify the essentials of fluid and electrolyte balance physiology without entering upon the complex details of physiological and physical chemistry. In order to do this, it is obviously necessary to sacrifice at times strictly scientific accuracy for the sake of clarity.

In the pre- and post-operative period the patient may have need for any one of several of the following:

1. Cells
2. Electrolytes
3. Water
4. Plasma
5. Adjustment of acid-base balance
6. Caloric intake to maintain metabolism
7. Vitamins

These needs should not be met by guess work, but by sensible utilization of the clinical and laboratory aids at our disposal:

1. We must consider the present and past nutritional status of the individual. Has he been taking adequate food, fluid, and vitamins by mouth? Is he thirsty? Is his skin dry? Is the output of urine adequate?
2. Complete blood count
3. Hematocrit—normal 46 per cent

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if high—hemoconcentration  
if low—hemodilution or microcytosis

4. Urinalysis—the specific gravity is of particular importance. (Urine concentration tests are an easy and reliable estimate of kidney function.)

5. Serum protein determinations

6. N.P.N., chlorides and  $\text{CO}_2$  combining power

7. Accurate intake and output records

It should be our aim to keep all these factors as near normal as possible. It must be emphasized, however, that the blood chemistry findings may approach normal while the patient's fluid and electrolyte balance are completely abnormal. The clinical condition of the patient is, in the last analysis, the most important factor.

#### PHYSIOLOGY

There are two great fluid compartments of the body:

A. Intracellular water—50 per cent of body weight

B. Extracellular water—25 per cent of body weight

1. Circulatory fluid

2. Interstitial fluid

Distribution of the fluid and electrolytes between these compartments is largely regulated by the phenomena of osmosis and the Donnan equilibrium. Osmosis so regulates materials on either side of a permeable or semipermeable membrane that they tend to reach an equilibrium of concentration on both sides of the membrane. Capillary endothelium and cell walls are selective semipermeable membranes. The filtration pressure of the blood stream tends to force fluid and electrolyte from the circulatory to the interstitial compartment. The osmotic pressure exerted by serum proteins tends to counterbalance this and keep fluid in the circulatory compartment. Ions tend to reach an equal concentration on either side of a semipermeable membrane. The capillary endothelium is normally not permeable to serum proteins. Under normal conditions they remain in the circulatory compartment and so tend to hold water there. If they fail, or escape from the circulation, osmotic pressure falls and electrolyte bearing fluid leaves the circulatory to enter the interstitial reservoir with the production of edema.

There is a delicate distribution of water and ions in the compartments. Water can pass readily into and out of the cells. The potassium ion is confined to the intracellular fluid. The sodium ion is in the extracellular fluid and it cannot permeate the cell membrane. Sodium and potassium tend to reach ionic equilibrium on either side of the cell membrane. Sodium passes readily from the interstitial to the vascular compartment and is also excreted in certain amount by the kidney.

The concentration of extracellular sodium regulates the degree of cellular hydration. If extracellular

sodium falls, the cells will take on water to lower the intracellular potassium concentration to equal that of sodium in the extracellular compartment. If the extracellular sodium rises, water leaves the cells to concentrate intracellular potassium until this equals the inionic concentration of sodium in the extracellular compartment. This gives cellular dehydration, and it is this process which is partially responsible for the phenomena of post-operative salt intolerance.

**WATER LACK.** Simple water deprivation or loss gives a dehydration of all fluid compartments and is characterized by: thirst, dry skin and tongue, oliguria, rising urine specific gravity (provided we have kidneys capable of concentrating well), slight hemoconcentration, rising N.P.N. In this situation the extracellular electrolyte (sodium) concentration rises. This draws water from the cells. However, normal kidneys should regulate the concentration of sodium, and if this is too high they excrete excess sodium to conserve intracellular water. Actually the kidneys do this, but water loss exceeds electrolyte excretion and the body in general remains dehydrated. Clinical dehydration, if the kidneys approach normal function, is accompanied by some degree of electrolyte depletion. Water loss or deprivation is therefore to be relieved by the administration of water and hypotonic electrolyte solution.

**SALT LACK OR LOSS.** Salt has great water binding power. Loss of salt results in extracellular dehydration with resultant cellular hydration, reduced plasma volume and hemoconcentration. It gives generalized weakness and an upset acid-base balance. It is not characterized by thirst nor relieved by water. Salt solution must be supplied to replace the electrolyte lack.

**EXCESS HYDRATION.** This can occur only in the presence of depressed renal output. All body cells swell giving water intoxication which sometimes results in convulsions, muscular tremors and generalized cerebral depression.

**EXCESS SODIUM CHLORIDE.** In the absence of gross loss of salt, the administration of excess sodium chloride may give salt and water retention with cellular dehydration. Sodium chloride solution remains extracellular where the electrolyte concentration is increased, and this causes an egress of water from the cells. The kidneys should excrete the excess sodium chloride to preserve cellular water, but this they often fail to do, particularly in the period of post-operative suppression of renal function. This retention of sodium chloride and water can be much aggravated by a low serum protein which allows water and electrolyte to accumulate in the interstitial fluid compartment producing clinical or subclinical edema.

**SHOCK.** The present day conception of shock is

that it represents a type of peripheral circulatory failure characterized by progressive reduction in circulating blood volume due to increased capillary permeability. There is a loss of protein bearing fluid from the circulatory compartment with lowered serum protein and raised interstitial protein. This brings about reduced blood volume and a hemoconcentration with reference to the cellular elements of the blood. Hematocrit and red blood cell count values rise. In shock we can readily have the establishment of a vicious circle, loss of blood volume—decreased peripheral circulation—capillary anoxia—further increase in capillary permeability—more plasma and electrolytes into the tissue spaces—further loss of blood volume.

Thus people in simple shock (without hemorrhage) need plasma and fluid to replace their lost or inactive circulatory fluid. Oxygen is of great value in combating capillary anoxia. Fluid alone is of only temporary value, for, in the face of a deficient and falling serum protein it will escape from the circulatory compartment.

Burn shock presents practically the same problem except that it gives an actual loss from the body of plasma protein, fluid and electrolytes. Later the development of anemia probably caused by toxic factors may in severe cases require transfusion. Some workers now feel that whole blood should be given to the exclusion of plasma in all cases with severe burns. We feel that both are usually needed, and that by carefully watching the red blood count and the hematocrit we can give plasma when it is needed and whole blood when it becomes necessary.

The dosage of plasma and electrolyte should be adequate to restore and maintain normal blood pressure, hematocrit and cell count, and establish an adequate urinary output. Rules of thumb have been shown to be inaccurate in certain instances, and in all cases the clinical condition of the patient and his status as regards the simple laboratory determinations should govern dosage of parenteral material. However, it is said that in shock the administration of 100 cc. of plasma for every point the hematocrit exceeds 45 per cent or 50 cc. for every point the hemoglobin is above 100 will usually suffice.

**HEMORRHAGE.** In hemorrhage there is a loss of all elements of the circulatory fluid compartment. Water is taken into the circulatory fluid in an effort to maintain the circulating blood volume. This gives hemodilution with a fall in the hematocrit, lowered cell count, and oliguria with rising urinary specific gravity. Eventually capillary anoxia ensues and allows increased capillary permeability with escape of plasma to the tissue spaces. Therapy should be instituted before this happens so oxygen is again important. In the treatment of hemorrhage, our course is more clearcut than in other situations. Blood is

easily available and should be given in quantity sufficient to approximate normal values. A hematocrit below 30 or a red blood cell count below three million is an indication for transfusion regardless of other factors in the condition of the patient.

**WATER REQUIREMENTS.** 1. We must replace already depleted body fluids. Many patients are dehydrated when we first see them. The patient who is clinically severely dehydrated is estimated to have lost or to be deficient to six per cent of his body weight. If we estimate his weight at 60 kilograms, we arrive at a 3600 cc. deficit which must be replaced in addition to supplying the daily need. Enough water should be given to allay thirst and lower the urine specific gravity to about 1.018.

2. There must be a daily replacement of SENSIBLE loss of fluid.

A. *Urine*—the normal kidney in a healthy adult which is capable of concentrating to 1.030 must excrete 600 cc. of urine daily to remove the normal waste products of metabolism. Post-operative tissue breakdown and fever increase the waste, and the kidneys may not be able to attain a specific gravity of 1.030 so we attempt to give enough water to assure a daily output of 1250 to 1500 cc. of urine.

B. Other drainage must also be replaced—vomitus, gastric suction fluid, biliary drainage, fluid from blood loss, etc.

3. We must replace the INSENSIBLE loss by perspiration and respiration which is estimated at 2000 cc. daily and this will always increase with fever and heat.

Coller's old rule for water replacement was as follows: Replace the sensible loss with isotonic saline solution; replace insensible loss with water and glucose; for each 100 mgm per cent that the plasma chlorides are below normal give 0.5 gm. NaCl per kilogram of body weight, and also provide 5.0 gm. total NaCl daily for maintenance. The latter has been found unnecessary because the ability of the kidneys to conserve sodium chloride is practically perfect.

Coller has retracted the above plan because he finds that it gives an excess of salt, and he has recently described the picture of post-operative salt intolerance. This is characterized by weakness, disorientation, nausea, vomiting and distension accompanied by a rising N.P.N., lowered CO<sub>2</sub> combining power in the face of constant blood chloride level. Accumulation of electrolyte bearing fluid in the serous cavities of the body may also take place. I think we have in years passed all seen this train of events, failed to recognize it and continued to add insult to injury by further administration of salt solution in an effort to restore the chemistry to normal.

The overload of sodium chloride in the post-operative period gives a hypertonicity with a shift of water from the intra to the extracellular fluid space. If post-operative fluid needs are supplied with isotonic saline solution, there will be approximately two liters of fluid transferred from the intra to the extracellular space. This situation is presumably caused by post-operative suppression of renal function due to anesthesia, shock, anemia, anoxia, and possible edema of the kidney itself.

Dr. Coller now recommends the following procedure for the regulation and supply of the need for water:

1. Supply enough water to allay thirst and maintain specific gravity of the urine below 1.020 with a daily volume of 1250 cc. to 1500 cc.

2. Give no sodium chloride in the first 48 post-operative hours except enough to replace the sensible extracellular fluid loss volume for volume with HYPOTONIC solutions (0.5 per cent NaCl fortified with 50 gm. of dextrose per liter or 1.38 per cent NaCl plus 0.11 NaHCO<sub>3</sub>).

3. After the first 48 hours give one liter of Ringer's solution daily in excess of the above volume for volume replacement of sensible extracellular fluid loss.

For the last several years we have followed this general scheme. We have noticed a marked improvement in the general well-being of our patients since we abandoned the use of normal saline in the post-operative period. It has been of particular satisfaction in cases of gastric or intestinal resection. If saline is withheld, our anastomoses begin to function practically immediately, and we have never seen a serious disturbance of electrolyte balance in the early post-operative period.

#### PROTEIN NEEDS AND NITROGEN BALANCE

Plasma protein is essential in maintaining adequate osmotic pressure in the circulatory compartment. If the plasma protein level is low, any one or several of the following frequent complications may ensue:

1. Decreased intestinal motility and distention probably due to edema of the bowel wall.
2. Retarded wound healing.
3. Depressed renal function.
4. Decreased resistance to infection due to edema and to the fact that the antibodies are carried by the globulin fraction.
5. Decreased liver resistance to toxins.
6. Delayed emptying of anastomoses.
7. Increased incidence of bed sores.
8. Delayed callus formation in fractures.
9. Increased incidence of thrombosis.
10. Generalized debility, anorexia and slow recovery of strength.

With these potentialities in mind, it follows that the plasma protein determination should be as much

a part of the pre-operative laboratory routine as the blood count and urinalysis.

In medical patients as well as in the pre- and post-operative cases we must beware of pre-existing protein nutritional deficit, lack of protein due to inability of some to take sufficient food by mouth, and loss by drainage, albuminuria and bleeding. Surgical procedures increase both the loss and the lack of protein. There is post-operatively an increased breakdown of protein, increased nitrogen excretion and decreased nitrogen intake. There often is liver suppression which interferes with proper utilization of amino acids and protein.

The clinical manifestations of depleted body protein (weakness, edema, anorexia, hypoproteinemia) are really late signs. If the serum protein level is low, we have already a severe deficit in the fixed tissues. Even this sign may be masked by the hemococoncentration of dehydration. The body attempts to maintain plasma protein at the expense of tissue protein. A loss of one gram of plasma protein indicates a loss of 30 grams of protein from the fixed tissues. For this reason, it often takes a tremendous increase in protein intake over a long period of time to restore both fixed and circulatory protein to normal.

Plasma given intravenously will replace lost or deficient serum protein, but it must be hydrolyzed to amino acids before it can be utilized to rebuild tissue protein. This is a slow process, if it occurs at all. The amino acids are the building blocks of protein, and we can now give them intravenously. These preparations have been practically reaction-free and will maintain positive nitrogen balance. A patient is in nitrogen balance when the intake is equal to the output, and in positive nitrogen balance when the intake is more than the output.

There are two outstanding products at present in the parenteral amino acid field. Parenamine (Stearns) is a 15 per cent solution of amino acids derived from the acid hydrolysis of casein and fortified with tryptophane. It provides 60 calories per 100 cc. Parenamine is supplied in 100 cc. stoppered bottles, the contents of which are added to our regular intravenous glucose solutions. Amigen (Mead Johnson) is supplied as a five per cent solution of amigen powder in five per cent glucose solution.

Dosage of parenteral amino acids: The following will keep most patients in positive post-operative nitrogen balance: One gram of amino acids (Amigen or Parenamine) per kilo per day and 400-600 cc. 15 per cent solution (Parenamine) per day.

(60-90 grams amino acids per day)

(8-12 grams Nitrogen per day)

2-3 liters five per cent Amigen with five per cent glucose per day.

The dosage must be individualized and larger quantities given to those who are severely depleted, dehydrated, or in those who are losing large quantities of nitrogen through urine or serous exudates.

If the caloric intake in the form of carbohydrate is not sufficient for body requirements, our amino acids will be deaminated and used as carbohydrate. It is possible then to fail in maintenance of nitrogen balance in spite of giving seemingly adequate amounts of amino acid or protein. The caloric supply, exclusive of that derived from amino acids, must be kept above basal level if our amino acids are to be used for tissue metabolism. We give enough carbohydrate to satisfy the caloric need, deposit glycogen, spare protein and replace fat in the liver.

#### CALORIC REQUIREMENTS

Two to three thousand calories per day should be provided the patient in the pre- and post-operative period. It is important to remember that caloric needs are increased by fever, and by the demands of wound healing. We should bear in mind the caloric values of the solutions we administer and choose that solution or solutions which most nearly will approach the current need.

It is well to remember that 50 cc. of 50 per cent glucose provides only 100 calories and so is insufficient alone as a source of carbohydrate in the pre- and post-operative period. The yield of 1000 cc. of 10 per cent glucose is approximately 400 calories. An amount of 1000 cc. of 5 per cent Amigen in 5 per cent glucose solution gives 385 calories; 100 cc. of Parenamine give 60 calories. It has now been adequately shown that alcohol added to our solutions enhances the carbohydrate caloric value and also provides a frequently desirable sedative effect. Alcohol contains about eight calories per cc. It can be added to intravenous glucose solutions to make a 5 per cent solution of alcohol, thereby adding some 400 calories per liter of solution. This has been a very successful and practical way of increasing the caloric supply and is harmless if the solutions are administered slowly enough to avoid intoxication. A total of 1000 cc. of 10 per cent glucose with 5 per cent alcohol will give an intake of approximately 800 calories.

#### VITAMIN REQUIREMENTS

There are now available for parenteral use many fine vitamin preparations. We attempt to provide an excess of each over the daily requirement. All operative patients should be considered at least mildly deficient in vitamins. The preparation which we use can be added to any of the intravenous solutions given to maintain fluid, electrolyte and caloric intake. It contains thiamine 10 mg., riboflavin 10 mg., pyridoxine HCl 5 mg., calcium pantothenate 50 mg., and nicotinamide 250 mg., in a 5 cc. ampoule which is added directly to our other solutions.

It has been shown that a large percentage of the population is deficient in vitamin C which is essential to proper collagen formation. Consequently we attempt to provide from 500 to 800 mg. of ascorbic acid daily either parenterally or by mouth in the pre- and post-operative period. This is added, with our B complex preparations to the bottles of glucose solution.

Vitamin K is necessary for the formation of prothrombin but is not absorbed properly when there is a deficiency of bile pigment in the intestine. This deficiency occurs particularly in the presence of obstructive jaundice. Vitamin K can be given by mouth provided desiccated bile is also given by mouth. We prefer to use the parenteral preparations either intravenously or intramuscularly as they seem to more surely and quickly return the prothrombin time to normal. No set dosage can be designated. Enough must be given to restore the prothrombin time to normal before operation. It is most important to continue Vitamin K in the post-operative period also. Despite the apparent operative relief of mechanical common duct obstruction, there is frequently edema which for some time prevents bile pigment from entering the intestinal tract, and patients usually do not take much by mouth immediately following biliary tract operations. A prothrombin time restored to normal before operation may, in the absence of the continuation of Vitamin K administration, again fall to a dangerous level. We have once seen the development of a large hematoma some days after the removal of a common duct stone when the continued administration of Vitamin K was overlooked in the writing of the post-operative orders for the patient.

#### ROUTE OF ADMINISTRATION

Any of the solutions can be given intravenously. This route provides a convenient, rapid and moderately comfortable infusion. We would like to warn against the dangers of repeated attempts to administer a venoclysis to the seriously ill patient. Such patients are quite often made most uncomfortable exhausted and even thrown into shock by multiple attempts at venipuncture. The introduction of the needle should be undertaken with as much care as possible, and once introduced should be so fixed that it will not come out. We prefer to use the veins of the hand and forearm rather than the larger veins of the anti-cubital fossa, because if the latter are utilized the patient is unable to flex the elbow without dislodging the needle. If forearm and hand veins are used, and the needle properly fixed, the patient may be allowed sufficient movement of the arm to greatly enhance his comfort.

The use of the conventional arm board must be condemned. If the proper veins are entered, a loose

"reminder" bandage about the wrist and fixed to the bedsprings will assure adequate immobilization. If possible, infusions should be started and completed during the day—don't keep the patient awake and uncomfortable the entire 24 hours.

When undertaking procedures which are time consuming such as colectomies or those which may involve unexpected and severe hemorrhage such as difficult nephrectomies, it is our practice to introduce a 15 gauge cannula into the greater saphenous vein at the ankle before operation. This procedure often avoids serious and potentially fatal situations at the operating table. Anticipation undoubtedly saves many lives. Should something serious develop in the course of an operation, one can rapidly supply through the cannula any needed quantity of blood or plasma. This is often a source of great satisfaction to the surgeon who finds himself in a difficult predicament. We have drilled small holes through the hubs of our cannulas so that they can be sutured to the skin besides being tied into the vein. With this added precaution, the patient can freely move his leg about, turn over in bed, and sit up without fear of becoming disconnected from his source of fluid. The cannula also saves the discomfort of repeated veni-puncture. The long saphenous vein can almost always be readily visualized and it is very constant in location just mesial to the internal malleolus.

For some time we have also utilized the intramuscular injection of our fluids. Saline, five per cent glucose, vitamins and diluted solutions of the amino acids may be given by this route. It is not suitable for more concentrated glucose or amino acid solutions. A long needle is introduced deep beneath the fascia lata on the lateral aspect of the thigh. The solution will be absorbed about as rapidly as it can be given intravenously through a 21-gauge needle, and patients never complain of any appreciable discomfort.

In view of the adequacy of the intramuscular route we have abandoned the more slow and painful subcutaneous administration of fluid and feel that it should no longer be used.

The administration of a hypodermic of morphine a half hour before starting infusions of blood or fluid has been shown to greatly reduce the chance of reactions and should be a routine procedure.

#### INTAKE AND OUTPUT RECORD

Every chart of a patient undergoing a serious operation and involving the administration of parenteral fluid should have a separate fluid balance sheet. Many types of such records have been devised and almost all are adequate. The intake-output record should be computed from 6 A.M. to 6 A.M. so that the completed fluid balance sheet for the previous 24

hours is available when morning ward rounds are made. This will allow the program for the next 24 hours to be laid out accurately. If the totals are made to midnight, as is the routine in some hospitals, we are from 8 to 12 hours behind on the record when we see the patient in the morning.

It is imperative that the nurses be impressed with the necessity for keeping accurate intake and output records. The attending physician must first display some real concern about the matter before he can expect the nurses to be interested in the problem.

We have not used the pectin and gelatin solutions which have been mentioned in the literature. If plasma, blood and amino acids are as readily available as is now the case, there seems little reason to resort to gelatin, pectin or other less natural preparations.

#### ACID-BASE BALANCE

It is obvious that what has been said of electrolyte balance depends in large part upon the presence of adequate kidney function. If the principles discussed above are adhered to, acid-base balance will cause no great problem. It is important, when the post-operative N.P.N. value begins to rise abruptly, to increase the quantity of glucose and water that is given in an effort to increase the output of urine. One again must beware of giving saline solution in excess of the plan as recently described by Coller. Saline may cause edema of the kidney with further depression of the renal function. If we simply supply the water and glucose, the kidneys continue to play their part as filters and the increased urine output will automatically carry off the excess products of nitrogen metabolism. It must also be remembered that a sufficiently high blood pressure must be maintained to supply the necessary filtration pressure for the formation of urine.

#### SUMMARY

It is now possible to provide parenterally practically all needs for fluid, calories, nitrogen, vitamins and minerals. The nutritional status of the patient may be maintained for weeks at a time while he is unable to take fluid or food by mouth. In meeting these needs we should utilize the laboratory aids at our disposal but should be guided even more by the clinical condition of the individual patient. It is essential to allay thirst and provide an adequate urine output of proper specific gravity.

Administration of excesses of sodium chloride, particularly in the period of postoperative suppression of renal function, frequently leads to cellular dehydration and the clinical picture of postoperative salt intolerance. Coller recommends that no sodium chloride be given in the first 48 postoperative hours

except to replace sensible fluid loss with hypotonic electrolyte solutions.

Maintenance of protein levels both in the fixed tissues and in the circulatory compartment is essential and may now be accomplished readily by the use of parenteral amino acids. These are practically reaction free and will maintain nitrogen balance adequately. We have used them in large quantity for several years without serious reaction. The amino acids have undoubtedly done much to improve the nutritional status of our surgical patients.

Caloric intake in the form of carbohydrate must be provided or body protein and administered amino acids will be utilized to meet the ordinary daily energy requirements. Caloric intake can be fairly accurately computed since one gram of glucose yields approximately four calories.

All the solutions can be given intravenously and the use of a cannula in the greater saphenous vein is frequently helpful. The intramuscular route beneath the fascia lata is preferred to subcutaneous infusion.

An accurate intake-output record is essential in all cases requiring any amount of parenteral feeding. Acid-base balance presents no great problem if the scheme advocated by Dr. Coller is used, pro-

Approximately 300 nurses from all sections of the country were recruited by the American Red Cross in August for poliomyelitis service in a dozen states, it was announced recently at national Red Cross headquarters. Kansas was one of the states needing nursing assistance at the time the disease reached its peak here. All states of the union except Nevada and Rhode Island have reported polio cases this year.

In addition to providing emergency nurses, the Red Cross, in cooperation with the National Foundation for Infantile Paralysis, has sponsored demonstrations and instructions in poliomyelitis nursing techniques. It is also continuing courses for Red Cross nurse's aides in care of convalescent polio patients.

Medicine today is as much a social as it is a biological science. The doctor is not merely a technician but must be an important factor in the shaping and guiding of any satisfactory plan of medical service. It has been quite apparent in recent years that the medical profession, so largely concentrating on individual techniques and methods of practice, has failed to produce long-term, constructive policies or a sufficient number of public minded leaders who are qualified by point of view or experience to guide the development of sound local and national plans for medical care.

The country needs wise, courageous leaders in medicine, cooperating with industry, labor and the public to meet the health needs of the country and avoid the errors and mistakes of other health service programs such as have developed in the last 60 years in Europe. We must develop plans which will be suitable to the needs of American society under the guidance and direction of professional personnel on professional matters. There is every reason to believe that with patience and consideration

vided kidney function approaches normal and the blood pressure is high enough to maintain filtration.

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of the complex adjustments that have to be made in the development of a medical service program adapted to the needs of present day society, the medical profession will be able to make a contribution of the greatest importance to the welfare of the country. If the profession is prepared to provide the necessary leadership and guidance, there is every reason to suppose that in substantial measure it will be able to remain in the position of determining the broad, over all professional policies.—*Willard C. Rappleye, M.D., in New York Medicine, August 6, 1946.*

The meat shortage may be to blame in part for the short supply of streptomycin. In production of the drug, which is penicillin's potent ally in fighting germ diseases, a need for beef pancreas was cited specifically by Dr. Chester S. Keefer, of Boston, at the American College of Physicians meeting in Philadelphia.

Trypsin enzyme from beef pancreas is needed for the preparation of streptomycin from the crude brew of soil organisms which produce the drug. Beef pancreas, however, is also needed to produce insulin for diabetes. At present insulin has also a high priority on the pancreas supply because there is not any too much insulin, without which thousands of diabetics would die.

Streptomycin production is much more difficult than penicillin production and the yield per quantity of fluid is smaller; about ten times as much streptomycin by weight as penicillin is required to treat a patient. From one-thirtieth to one-eighth of an ounce of streptomycin is required daily in the average case. It must be given by injection every three to four hours. This also contributes to the difficulty in getting enough of the drug to treat all the patients who want it.—*Science News Letter, May 25, 1946.*

## Announcement of Hospital Allotments

Allotment figures to the states for the five-year hospital construction program authorized in the Hospital Survey and Construction Act were released last month by Surgeon General Thomas Parran of the United States Public Health Service. Kansas is allotted \$37,908 for survey and planning and \$933,750 for construction. On a national basis, the act authorizes the appropriation of \$3,000,000 for surveys and \$75,000,000 annually for five years for construction.

Of these amounts, only \$2,350,000, earmarked for surveying and planning, has been appropriated to date. All states are to share in this amount on the basis of population, although a formula taking into consideration both population and per capita income will be used in allocating appropriations for construction.

Formation of a Division of Hospital Facilities to assist the surgeon general in carrying out the provisions of the act was recently announced. The division will be responsible for carrying out the functions which the U. S. Public Health Service is authorized to perform in accordance with the provisions of the act. This includes assistance to the states, their political subdivisions, and non-profit organizations in matters relating to the study, construction and operation of hospitals. In addition the division will assist in preparing regulations, determining allotments and grants and considering applications, plans and projects.

## Purchase Trueheart Clinic

Dr. George Gill and Dr. Jack Dysart, associated in the Trueheart clinic at Sterling for several years with the late Dr. Marion Trueheart, recently announced that they had purchased the clinic and Dr. Trueheart's interest in the Sterling Hospital Association. They will continue to operate the clinic in the same manner in which it has functioned since its organization.

## Examinations In Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology, Inc., has announced that the next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 7, 1947. All applications must be in the office of the secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania, by November 1, 1946.

## Parergon To Be Published

The Mead Johnson Company, long interested in art works by physicians, announces that the new edition of Parergon is now in preparation. Physicians who wish to have their work considered for inclusion in Parergon are asked to send glossy photo prints (8 by 10 preferred) to Editor, Parergon, Mead Johnson and Company, Evansville 21, Indiana. Art work considered may be in any of the following fields: oils, watercolors, sculptures, drawings, pastels, prints, etchings, engravings, lithographs, woodblocks, photographs, colored photographs, ceramics, woodwork, metalwork, jewelry, needlework, shipmodels.

The company also announces that the \$34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City session of the A.M.A. in June, 1947.

It would be premature to make extensive claims about the merits of dicumarol in the treatment of coronary thrombosis. Adequate controls with which to determine

its value statistically are not yet available and will be of little value unless several subdivisions depending on the severity, extension, and complications of each group are studied separately. Each of these subdivisions must contain a statistically significant number of controls and treated patients. This will be a long and difficult but important evaluation.—*Irving S. Wright, M.D., in American Heart Journal, July, 1946.*

Infectious hepatitis occurs sporadically and in epidemic form over a wide geographical area. It seems certain that the disease is caused by a specific virus with an apparent affinity for the liver. The disease in most cases confers lifelong immunity.

The transmission of infectious hepatitis, on the basis of present knowledge, takes place by contact of a susceptible person either with a patient having the disease or with material contaminated by the causative virus. It seems certain that the virus can be carried in food. It may be carried in water.

A plea is entered for the recognition and careful handling of infectious hepatitis. This disease clearly may cause irreversible liver changes. Our observations lead us to believe it is a serious disease in pregnant women.

Gamma globulin has no place in the treatment of the active phase of infectious hepatitis. It has been shown to be capable of producing immunity of six to eight weeks' duration and should be useful in the control of small outbreaks. Further study may prove that gamma globulin given during the incubation period can modify infectious hepatitis, in a manner similar to its action in measles.—*Harriet L. Hardy, M.D. and Roy Feemster, M.D., in New England Journal of Medicine, August 1, 1946.*

Malignant tumors of the jejunum and ileum are extremely difficult to recognize unless they cause obstruction. Some refinements of technic are now available, from which conclusions may be drawn as to the probable malignancy of obstructive lesions of the small bowel. It may be necessary to introduce a Miller-Abbott tube to the site of obstruction, and instill barium for careful fluoroscopic and spot-film study. Complete visualization of the small bowel may be secured by fractional administration of the barium meal; careful fluoroscopy may then enable the roentgenologist to detect the site of the lesion and study its contours. The diagnosis, however, is rarely made early because the patient usually is first seen during an obstructive crisis, when there is neither opportunity nor time for a study of the finer details of the mucosal pattern after locating the probable site of obstruction.—*Illinois Cancer Bulletin, July 25, 1946.*

While some of the histamine-neutralizing drugs in production and under clinical investigation are undoubtedly of great value, the belief expressed in some quarters that a universal treatment for allergy is imminent is not yet justified. From past experiences with the indiscriminate use of torantil, however, we can expect that when these histamine-neutralizing agents of greater potency become generally available, they will be widely used in all types of disorders, allergic and otherwise. It is well for the allergist to be prepared to evaluate properly the uses and limitations of these drugs.

The new agent, benadryl, will be of inestimable value in controlling the acute allergic phenomena, some of which have always been difficult to manage. It also gives the allergist an opportunity to search for the fundamental allergic factors, in the hope of securing lasting results.—*L. C. Todd, M.D., in North Carolina Medical Journal, July, 1946.*

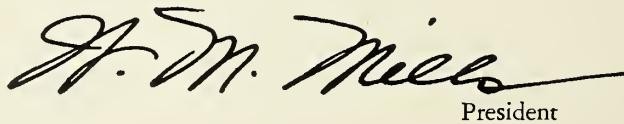
## PRESIDENT'S PAGE

*To the Members of the Kansas Medical Society:*

The Auxiliary of the Kansas Medical Society has grown steadily and healthily until it now has 538 members actively engaged in constructive medical projects. It would be difficult to overestimate the present influence of this group or its possibilities in the future with enlarged membership and a fine bulletin of their own.

The greatest contribution of the Auxiliary to date has been in combating compulsory health insurance and any increase in the furnishing of medical care by physicians who are servants of the state. This opposition to the control of medicine by government is a continuing process which cannot let up until the measure S. 1606 is decisively defeated. We must not be lulled into inaction by the recess of Congress.

As intelligent citizens we must admit the defects in the distribution of medical care and aid in their correction through improved sanitation, nutrition, housing, hospitalization facilities, and working conditions. Voluntary health insurance, started only nine months ago in Kansas, is proving a success and in a few years should be serving a large portion of the population. The Auxiliary can do a fine piece of work in educating the public about this service which provides good medical care for low income groups at prices they can afford on a prepayment basis. We only ask a little time to show what can be done by democratic methods.



H. M. Miles  
President

## EDITORIALS

### Streptomycin Now Available

The National Research Council has announced that streptomycin has been made available to the profession beginning September 1 and will be distributed through authorized hospital depots. The new drug is a potent antibacterial agent. However, the results have been less spectacular than the press notices have portrayed during the past year.

The local hospitals have been notified what their allowances of the drug will be. A 100-bed hospital will receive 30 grams each month. The recommended dosage varies from five grams in tularemia and *Hemophilus influenza* meningitis to as much as 70 grams in brucellosis or in *Salmonella* infections. A physician who treats one of the latter group will be using all the streptomycin allocated to one hospital for a two-months period.

The Council has grouped the susceptible infections in two groups. In the first are definitely susceptible infections while in the second group the results have been less promising.

The high cost of the agent is also an important factor. The retail price at present is slightly over \$26 per gram, or \$260 for enough of the drug to treat the average urinary tract infection due to organisms resistant to other drugs. If 70 grams are used in a brucellosis, the cost of the drug will be \$1,820.

"Streptomycin has been most effective in the treatment of tularemia, *Hemophilus influenza* infections, urinary tract infections due to gram negative bacilli, bacteremias and meningitis due to gram negative bacilli." (1) (2) The results in typhoid, brucellosis, *Salmonella* infections, peritonitis and pulmonary infections due to Friedlander's bacillus and other gram negative organisms have been inconclusive. At present its use in infections due to *Mycobacterium tuberculosis* is impractical. Streptomycin should be given intrathecally in meningitis cases and intrapleural injections used in the treatment of empyema to supplement the intramuscular doses.

It is obvious that each hospital should establish rules to insure maximum effectiveness and equitable distribution of its limited supply of the drug. It has been suggested that a committee consisting of a surgeon, an internist and the laboratory director have

this responsibility. They would investigate each request for the drug and release it only to those within Group I, unless a sufficient reserve can be built up to justify using it when it is of doubtful value.

The physician prescribing streptomycin should not forget the high cost of the drug.

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### It Is Still a Privilege Vote November, 1946

It is still a privilege to be able to cast your vote for those men who have expressed themselves as candidates for the varying public offices. It is one of our rights as established by the Constitutions of the United States of America and the State of Kansas.

Individually, our weak little voices may not have much to do with the progress of the state and of the nation, but collectively, enough individuals, thinking and voting along the same lines, can exert a powerful influence upon the pattern of future legislation, be it medical, social or economic.

We therefore urge you to talk to various candidates, get your finger on their pulse, test out their brain waves, see what they stand for, make your decision and then cast your vote.

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### The Art of Medicine

Since antiquity the Art of Medicine has been recognized and utilized in many and varied diagnostic and therapeutic situations. It is far more ancient than the science and has developed with the cultures of our civilization. It has been defined as the practical application of the teachings of medical science. It is inclusive, the utilization of all known diagnostic and therapeutic measures, and also the manner in which all dealings with the patient are conducted. Perhaps the student in recent times has been given poorer training in the Art of Medicine than his predecessor because of the changing methods of scientific teachings.

It has been most aptly and appropriately stated by Houston that the placebo, something to please the patient, has always been the norm of medical practice. In spite of all the scientific progress, we still use drugs and other agents empirically, at first questioning their effects, later becoming boldly enthusiastic advocates for them. Many of these drugs or agents succeed in "ratio to the psychological influence of the physician and to the psychopathic complex of the patient."

Isn't it still true that in many conditions the advice, encouragement or counsel with the patient is far more important than the particular agent used? In fact in many illnesses the prescribing of a non-specific or therapeutically impotent drug is only a

(1) *Streptomycin in the Treatment of Infections*, Chester S. Keefer, M.D., Chairman Committee on Chemotherapeutics and Other Agents, National Research Council, J.A.M.A., Volume 132, Number 1, September 7, 1946.

(2) *Streptomycin in the Treatment of Infections*, Chester S. Keefer, M.D., J.A.M.A., Volume 132, Number 2, September 14, 1946.

contact and the physician himself is the patent therapeutic agent. With all the radio, periodical, and detail man advertising at this time, it is little wonder that we "fall for" and utilize many therapeutic agents that will soon be forgotten (or at least should be).

The advancement of medicine will undoubtedly in the future, as in the past, be based upon scientific achievements, but it is to be hoped that the Art of Medicine will also approach some degree of perfection. It is only in the direction of a rational practice that we can visualize the continued progress of our profession. This must come about not through political manipulations, nor through public clamor, but through the increasing efforts of physicians to improve themselves and to eliminate ignorance and incompetence from our ranks.

### DEATH NOTICES

#### ARTHUR EMANUEL HERTZLER, M.D.

Dr. Arthur E. Hertzler, 76, prominent surgeon and writer of Halstead, died September 12 at the hospital he founded in Halstead in 1902. He had retired from active surgical practice last February but had maintained contact with the clinic and hospital as a consultant.

He received the M.D. degree from Northwestern University Medical School in 1894 and did post-graduate work in Berlin from 1899 to 1901. On his return from Germany he taught pathology for five years at the University Medical College of Kansas City, and then for two years was surgeon and gynecologist there. In 1909 he became professor of surgery at the University of Kansas School of Medicine.

He had practiced surgery at Halstead for many years, and it was there also that he wrote many books, "Surgical Operations with Local Anesthesia" published in 1913, "The Peritoneum" published in 1919, and "Diseases of the Thyroid Gland," in 1922. He became widely known after publication of "The Horse and Buggy Doctor" in 1938, a book that has passed through 45 editions.

He was a member of the Harvey County Medical Society, the American College of Surgeons, the American College of Anesthetists, and the American Microscopical Association, of which he was president in 1911. He was also a member of the founder's group of the American Board of Surgery.

He is survived by his widow, associated with him professionally as Dr. Irene Koeneke, chief gynecologist at the Halstead clinic.

\* \* \*

#### FLORENCE P. SIMMS CHAPMAN, M.D.

Dr. Florence P. Chapman, 69, a member of the staff of the Topeka State Hospital for more than 20 years, died September 10 while visiting in Akron, Ohio. A graduate of Ohio Medical University in Columbus, Dr. Chapman specialized in psychiatry. She was a member of the Shawnee County Medical Society.

### COUNTY SOCIETIES

Dr. E. H. Gibbons, director of the Veterans Administration Medical Service Center, Topeka, has been speaker at a number of county society meetings during the past month, explaining details of the agreement between the Veterans Administration and the Kansas Medical Society and regulations covering examinations and treatment.

Dr. Gibbons spoke first at a meeting of the Saline County Medical Society at Salina on September 12, then at a meeting of the Butler County Society at El Dorado on September 13. On September 17 he met with members of the Cherokee County Society and had a part on the program along with Doctors Charles S. Huffman of Columbus, Clem Jones of Galena, C. H. Benage of Pittsburg and D. B. McKee of Pittsburg. He addressed a meeting of the Cowley County Society on September 19 and a meeting of the Riley County Society on September 24.

\* \* \*

A meeting of the Marshall County Medical Society was held August 22 at the Hotel Pacific, Marysville. A business session was held, at which members voted to sponsor a proposed new memorial county hospital, and a scientific program included the showing of movies on intravenous anesthesia.

\* \* \*

The Central Kansas Medical Society met September 26 at Ellsworth for a scientific program in the afternoon followed by dinner and a social program in the evening. Dr. Lawrence P. Engel, Kansas City, Missouri, discussed "Recent Developments in Surgery of the Upper Abdomen," and Dr. Harold T. Gainey, Kansas City, Missouri, spoke on "Management of Prolonged Labor."

\* \* \*

The Riley County Medical Society, at a meeting held at Manhattan September 5, voted unanimous approval of petitions now being circulated urging construction of the proposed Riley County Memorial Hospital.

\* \* \*

The September meeting of the Johnson County Society was held at the office of Dr. George L. Maser in Mission. Dr. H. A. Wenner of the University of Kansas School of Medicine was speaker of the evening and led a discussion on poliomyelitis.

\* \* \*

A meeting of the Marion County Medical Society was held at Marion September 4. A scientific program was presented with Dr. W. W. Tate of Peabody discussing vascular disease and the use of exercise in treatment, Dr. A. K. Ratzlaff of Goessel speaking on injection and ligation of varicose veins, and Dr. R. R. Melton of Marion reviewing treatment of leg ulcers.

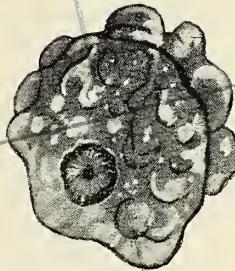
\* \* \*

Members of the Clay County Medical Society held a dinner meeting September 11 at Cedar Court Lodge at Clay Center, followed by a scientific program at the Clay Center Municipal Hospital. Dr. R. Bruce McVay introduced a guest, Dr. Eugene Goforth, who is on the psychiatric staff of Winter Hospital, Topeka. Dr. Goforth discussed common psychiatric problems seen in Army and civilian life. Other guests of the Society were Dr. John Lattimore, Topeka, and Doctors George Bale, Jr., and Paul Adams.

### Writes On Photo Micrography

Dr. A. J. Brier, Topeka, is the author of an article on photo micrography which appeared in the September issue of American Photography.

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## Veterans Administration Agreement

Medical care under our agreement with the Veterans Administration is still not entirely understood by many members. There is repeated below a summary of the basic regulations. If these are complied with, the examiner will have less difficulty with this program.

### EXAMINATIONS

The adjudication service makes the decision on all claims for pension. Whenever it appears that additional medical information is needed, the rating board will order a clarification or an additional physical examination. Many of these will be made in the veteran's local community under our agreement. In each instance an authorization is mailed and the examiner is selected by rotation if there are two or more in the locality.

Occasionally doctors have called the Medical Service Center in Topeka requesting authorization to make an examination for a veteran. Such authorization can never be granted since every authorized examination to be paid for by the Veterans Administration must be first requested by the adjudication service.

If a veteran requests an examination to be made and an authorization for this examination has not been received, the physician may make the examination if he wishes and may send it to the regional office. Payment for this examination is the patient's responsibility. Since the Veterans Administration did not request this examination, they will not pay for it. The reason is obvious. A veteran dissatisfied with his rating might go to many doctors, hoping eventually to find one who can produce evidence that will allow his case to be reopened. Should the veteran succeed in having his case reopened, then the Veterans Administration probably would authorize additional examinations. They are, therefore, willing to accept examinations made on any veteran but will pay only for those they have requested.

### TREATMENT

Space prohibits a complete explanation of this topic. The following outline, however, will give the general picture. Cases that do not fit into the outline should be referred to the director of the Medical Service Center in Topeka for decision.

Office and home treatment for men and women can be authorized for service-connected disabilities only.

Hospital care for men is for service-connected disabilities only.

Hospital care for women may include any disability, whether service-connected or not, with the exception of normal pregnancy and syphilis acquired out of line of duty.

Veterans studying under Public Law 16, male or female, are eligible for all care, whether or not disabilities are service-connected. This is not to be confused with the regulation covering students who are under the G. I. Bill of Rights, Public Law 346, who are eligible only for service-connected disabilities as defined above.

A service-connected disability, broadly speaking, is an illness or a disability which occurred or was aggravated during his or her military service. In certain instances, as in malaria or the presence of shrapnel, the condition may be considered service-connected even though the record does not substantiate the fact. A third method of determining a disability to be service-connected is through the adjudication service of the Veterans Administration.

Always write the Medical Service Center in Topeka before treating a veteran. In cases of emergency, telephone for authorization. The Veterans Administration will pay only for those specific items in the treatment of the veteran that have been authorized. Should additional services be necessary, additional authorization must be obtained.

In applying for authorization for treatment, always give the patient's name, his claim number or his Army serial number. Give a diagnosis and the type and duration of treatment that will be required.

### THE HEART CLASSIFICATION

The section below is reprinted from the Manual for Medical Examiners published by the Veterans Administration. It is requested that every examination pertaining to the heart comply with the classifications that are listed hereafter, since the rating board uses disability tables that are geared to these classifications.

The following examples illustrate the construction of a diagnosis under this system:

I. (1) *Cause*.—Syphilis.

(2) *Structural lesion*. Aortic insufficiency; cardiac enlargement.

(3) *Manifestations*.—Myocardial insufficiency; ventricular premature contractions.

(4) *Capacity for work*.—Class V.

These characterizations may also be recorded as: Syphilitic disease of the heart, with aortic insufficiency, cardiac enlargement, myocardial insufficiency, ventricular premature contractions; class V.

II. (1) *Cause*.—Coronary arteriosclerosis.

(2) *Structural lesion*.—Myocardial damage.

(3) *Manifestations*.—Anginal syndrome.

(4) *Capacity for work*.—Class III.

This characterization may also be recorded as: Coronary arteriosclerotic disease of the heart, with myocardial damage and the anginal syndrome; class III.

III. (1) *Cause*.—Rheumatism (rheumatic fever).

(2) *Structural lesion*.—Mitral stenosis. Cardiac enlargement.

(3) *Manifestations*.—Auricular fibrillation. Myocardial insufficiency.

(4) *Capacity for work*.—Class IV.

This characterization may also be recorded as: Rheumatic disease of the heart, with mitral stenosis, cardiac enlargement, auricular fibrillation, myocardial insufficiency; class IV.

IV. (1) *Cause*.—Syphilis.

(2) *Structural lesion*.—Saccular aneurysm.

(3) *Manifestations*.—Pain.

(4) *Capacity for work*.—Class IV.

This characterization may also be recorded as: Syphilitic disease of the aorta, with saccular aneurysm and pain; class IV.

V. (1) *Cause*.—Hypertension.

(2) *Structural lesion*.—Cardiac enlargement.

(3) *Manifestations*.—Myocardial insufficiency.

(4) *Capacity for work*.—Class II.

This characterization may also be recorded as: Hypertensive disease of the heart, with cardiac enlargement and myocardial insufficiency; class II.

VI. (1) *Cause*.—Hypertension and coronary arteriosclerosis.

(2) *Structural lesion*.—Myocardial damage; cardiac enlargement.

(3) *Manifestations*.—Anginal syndrome; intraventricular block.

(4) *Capacity for work*.—Class IV.

This characterization may also be recorded as: Hyper-

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Calories per ounce	14	15	17	15	14
Crude Fibre %	0.15	0.29	0.30	0.22	0.43
Calcium %	0.026	0.013	0.046	0.046	0.024
Phosphorus %	0.042	0.065	0.068	0.068	0.051
Iron Mg. per 100 g.	.22	.72	.35	.40	.73
Copper Mg. per 100 g.	.24	.35	.12	.17	.24
Manganese Mg. per 100 g.	.075	.173	.054	.053	.018
Vitamin A—I. U. Per 100 g.	1766	7000	1130	1693	2550
Thiamine Mg. per 100 g.	.018	.080	.036	.037	.069
Riboflavin Mg. per 100 g.	.040	.62	.068	.072	.064
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tension and coronary arteriosclerosis, with myocardial damage and cardiac enlargement, anginal syndrome and intraventricular block; class IV.

*Class I.*—Patients with a cardiac disorder who are able to carry on ordinary physical activity without symptoms.

*Class II.*—Patients with a cardiac disorder who develop symptoms with ordinary physical activity, but are able to carry on slightly reduced physical activity without symptoms.

*Class III.*—Patients with a cardiac disorder who are unable to perform more than moderate physical activity (ordinary activity, moderately reduced) without symptoms of myocardial or coronary insufficiency.

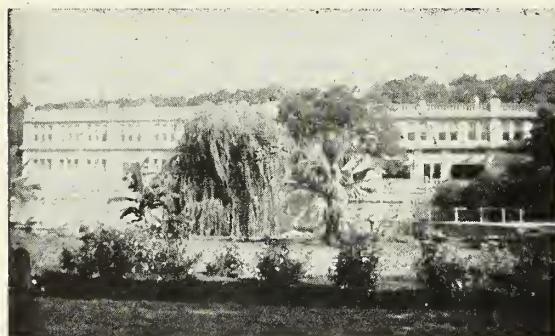
*Class IV.*—Patients with a cardiac disorder who develop symptoms and sometimes signs of myocardial or coronary insufficiency on more than greatly limited activity. Such patients are not usually employable in industry, although they may pursue purely sedentary occupations that do not require speed or effort.

*Class V.*—Patients with a cardiac disorder who are unable to perform any exertion without symptoms and signs of myocardial or coronary insufficiency, and are confined to bed.

### New Quarterly Journal

The publication of a new journal, the Quarterly Review of Dermatology and Syphilology, has been announced by the Washington Institute of Medicine, Washington, D.C., as an event marking its fifteenth year in the fields of medical publication and library research. It is the tenth in the Institute's group of reviews covering specialized fields of practice.

The new publication will survey all published material on dermatology and syphilology appearing anywhere in the world from January 1, 1946, onward.



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## ANNOUNCEMENTS

October 7-10—Fall Conference, Kansas City Southwest Clinical Society, Kansas City, Missouri.

October 7-11—Course in Clinical Allergy, sponsored by American Academy of Allergy, Marquette University School of Medicine, Milwaukee, Wisconsin.

October 9-12—Examinations, American Board of Ophthalmology, Chicago, Illinois.

October 21-23—Assembly, United States Chapter International College of Surgeons, Detroit, Michigan.

October 28-31—Fall Clinic, Oklahoma City Clinical Society, Oklahoma City, Oklahoma.

October 28-November 1—Annual Assembly, Omaha Mid-west Clinical Society, Omaha, Nebraska.

November 17-23—Inter-American Congress of Radiology, Havana, Cuba. Information may be secured through American College of Radiology, 20 North Wacker Drive, Chicago, Illinois.

December 4-5—Meeting, Kansas State Board of Medical Registration and Examination, Kansas City, Kansas.

December 7-12—Fifth Annual Meeting, American Academy of Dermatology and Syphilology, Cleveland, Ohio.

March 17-20—Sixteenth Spring Clinical Conference, Dallas Southern Clinical Society, Hotel Adolphus, Dallas, Texas.

April 28-May 2—Annual Session, American College of Physicians, Chicago, Illinois.

MAY 12-15—ANNUAL MEETING, KANSAS MEDICAL SOCIETY, TOPEKA, KANSAS.

## BOOKS RECEIVED

*Complete Handbook on State Medicine.* By J. Weston Walch. Published by Platform News Publishing Company, Portland, Maine. Copyright 1946. 170 pages. Price \$2.50.

The Library of the Medical Department of the University of Kansas has every desire to be of service to the medical profession in the state. Any physician who wishes to avail himself of the facilities of the Library will be welcome both in the use of its periodicals, bound volumes of periodicals, and monographs and textbooks.

Under certain circumstances, provided the volumes are not being actively used by the students, the Library will send such volumes as are needed to physicians in the state, on request, for a period of one week, provided carriage charges are paid both ways.

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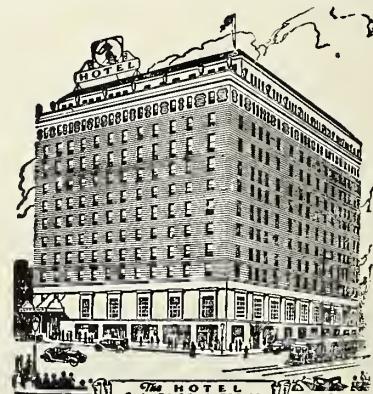
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Volume XLVII

NOVEMBER, 1946

Number 11

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**THE TREATMENT OF BENIGN MENOPAUSAL BLEEDING\***

J. Robert Willson, M.D.\*\*

Chicago, Illinois

The decline in ovarian function which characterizes the normal climacteric is in most instances accompanied by a decrease in menstrual flow which may manifest itself either as a diminution in amount of bleeding or a prolongation of the interval between periods. Any increase in flow, decrease in the intermenstrual interval, or irregular bleeding should be considered to be abnormal and demands complete investigation to determine the cause. Since the incidence of genital tract malignancy is at a peak during the age period in which the menopause may be expected, the main diagnostic efforts are directed toward eliminating carcinoma as a factor in the bleeding.

The principal benign lesions associated with increased climacteric bleeding are (1) irregular endometrial stimulation by the failing ovary, (2) uterine fibroids, (3) cervical polyps, (4) pelvic inflammatory disease, (5) medical complications (hypertension and blood dyscrasias), and (6) accidents of pregnancy. To assume, however, that the bleeding is of benign origin without complete investigation is dangerous. Miller and Sehring,<sup>1</sup> studying a group of patients on whom a *clinical* diagnosis of fibroids had been made, found corpus carcinoma to be present in 11.7 per cent at the time of curettage. Thus it is apparent that malignancy can never be eliminated with certainty by examination alone. Any bleeding patient deserves the benefit of the immediate application of all diagnostic methods available for the detection of genital tract carcinoma.

The investigation of such a patient includes a complete history and physical examination and a careful evaluation of the pelvis. Bimanual examination alone is insufficient because unless the cervix is carefully visualized through a speculum, small polyps or even early cervical malignancy may be overlooked. Suspicious lesions of the cervix, particularly ulcerated or

proliferating lesions which bleed upon manipulation, should be considered malignant until proven otherwise by microscopic examination of a piece of tissue removed from that area. Should no cause for the bleeding be discovered it must be assumed that it is coming from the interior of the uterus and a diagnostic dilatation and curettage is a necessity. This procedure must be carried out in the hospital with the patient anesthetized, at which time a more thorough examination can be made and with the entire uterine cavity curetted; while endometrial tissue can be obtained in the office, this cannot be depended upon to rule out malignancy because the removal by this method is so incomplete. Since the presence of carcinoma cannot always be detected by gross inspection of the endometrium, the tissue must be examined microscopically by a pathologist qualified to interpret correctly the changes which may be present; at times the differentiation between cancer and benign hyperplasia is most difficult and can only be made by the individual who is experienced in the examination of curettings.

After it has been established that the bleeding is of benign origin, a decision as to type of treatment must be made. In most instances control of bleeding is necessary; however, occasionally the abnormal blood loss is so slight that the patient may be observed without therapy; this particularly is true in the patient in her late 40's when cessation of bleeding may be expected momentarily. In the remainder two courses are available: hysterectomy, or the establishment of a radiation menopause. Each of these is an acceptable method for the control of bleeding but each has both its indications and its contraindications, and every patient should be considered individually in the light of her acceptability for either method before a decision is made. There is no place for the use of hormonal preparations in the treatment of menopausal bleeding.

Hysterectomy obviously will completely eliminate the uterus as a source of bleeding and may well be

\*Presented at the 87th annual session of the Kansas Medical Society, Wichita, Kansas, April 25, 1946.

\*\*From The Department of Obstetrics and Gynecology, The University of Chicago, and the Chicago Lying-in Hospital.

selected in patients who are good operative risks and particularly in those in whom there are contraindications to irradiation. The uterus may also be removed if adequate facilities for the roentgen destruction of ovarian function are unavailable. The mortality rate from hysterectomy in these patients should be minimal provided the operative procedure is not done in the face of contraindications, and that intelligent pre- and postoperative care is given.

Irradiation, either by deep x-ray therapy or intrauterine radium, may be utilized to control bleeding in carefully chosen cases at the menopause. Of utmost importance is an evaluation of the patient with particular regard to any condition which might make this method either hazardous or a failure. The contraindications to the establishment of a therapeutic menopause are:

1. *Age.* Since the effect in stopping bleeding is primarily a result of the destruction of ovarian function and precipitation of the menopause, this procedure should be reserved for patients over the age of 42. Those younger than this are better treated by hysterectomy with conservation of at least one ovary in order that it may continue to secrete its hormone and delay the onset of climacteric symptoms.

2. *Size of the uterus.* The uterus containing fibroids, the total mass of which is larger than the size of a 10-12 weeks pregnancy, should be removed. Those smaller may be irradiated if there are no symptoms other than the bleeding; pain and pressure symptoms on surrounding organs will not be relieved by merely stopping bleeding; therefore, surgical removal is the method of choice in such cases.

3. *Type of tumors.* Pedunculated fibroids either submucous or subserous contraindicate irradiation. Bleeding resulting from the former will not be controlled and the latter are always in danger of undergoing torsion of the pedicle or degeneration due to inadequate blood supply. Tender soft tumors may be degenerated and should be removed since the possibility of their becoming infected is always present.

4. *Ovarian Neoplasms.* The impossibility of accurately diagnosing the type of ovarian tumor or the presence of malignancy by physical examination alone makes surgical intervention in such cases imperative. The amount of radiation necessary to produce castration has no effect upon ovarian neoplasms and subsequent surgery would in most instances become necessary.

5. *Pelvic inflammatory disease.* The manipulation required for the introduction of radium may flare up old quiescent inflammatory processes in the adnexae with a resultant peritonitis and in some cases abscess formation. Surgical removal in such cases is preferable.

6. *Previous pelvic surgery.* The normal peristaltic

action of free loops of bowel prevents any particular segment from over-irradiation, but if bowel is adherent to the uterus as a result of previous surgery it may be irradiated to a degree which results in tissue destruction with subsequent stenosis or even perforation.

7. *Radiophobia.* Certain individuals have a marked fear of irradiation because of its association with the treatment of cancer. If they cannot be convinced of the benignity of the lesion for which radiation is to be given, surgery is a preferable procedure.

#### TECHNIC OF IRRADIATION

A most important factor in the final result from radiation is the proper application either of x-ray therapy or radium. Unless one is entirely familiar with the effects of radiation and with the methods of applying it, surgical treatment is preferable. Failures are usually due either to undertreatment or to a selection of cases in which the method is contraindicated. Incomplete or temporary castration should never be considered in the menopausal age; each patient should be given a dosage calculated to eliminate ovarian function permanently.

X-ray therapy must be administered by a trained radiologist with equipment designed to deliver an adequate dosage to the midpelvis. Because there occurs a diminution in effectiveness of radiation as it passes through tissue, the dosage to the skin should be calculated on a basis of how much is desired in the region of the ovaries. By measuring the anterior-posterior diameter at the symphysis and by computing from depth dose tables the approximate loss in effect at the midpelvis, the skin dosage may be calculated. Brown, et al.,<sup>2</sup> have shown that the dosage most consistently producing permanent cessation of ovarian activity is about 600 r to the region of each ovary; as the dosage was decreased the percentage of failure increased.

The effect of radium applied in the uterine cavity is twofold: (1) destruction of ovarian function and (2) a local sclerotic effect on the endometrium. Since the primary effect is destruction of tissue, great care must be taken to assure both proper filtration and placement in the uterine cavity. If the radium element is placed in a capsule with a filtration capacity equivalent to that of 1½ mm. of platinum, the locally destructive alpha rays will be filtered out in the capsule leaving only the deeply penetrating gamma rays to exert their influence on the ovary. This eliminates over-irradiation and destruction of the uterine wall and decreases the possibility of ulceration and infection. The radium should be placed entirely within the body of the uterus, leaving only an empty capsule in the cervix to prevent destruction of cervical tissue and stenosis. Distention of the vagina with a pack will aid not only in hold-

ing the capsule in the uterus but will increase the distance between the bladder and rectum and the source of radiation; an indwelling catheter will likewise aid in keeping the bladder empty thus protecting it from over-irradiation.

The total dosage from the radium should be approximately 2000 mg. hours to insure permanent castration; less than this may be associated with failures, the number of which increases as the total dosage diminishes.

On the surface this method appears to be a simple procedure for the control of benign menopausal bleeding; however, it may be more dangerous and result in more complications than hysterectomy unless it is utilized with caution and with a complete understanding of the potentialities of radium.

The complications which may arise are:

1. Chronic ulceration, infection, and discharge from the uterine cavity as a result of inadequate filtration of the soft, locally destructive alpha rays or of over-irradiation of a small area due to improper placement of the capsule.

2. Cervical stenosis and pyometria following destructive irradiation to the cervical canal.

3. Vesicovaginal or rectovaginal fistulas should the radium be placed in such a manner that it over-irradiates the vagina or should the capsule slip from the uterus and lie in the vaginal canal.

4. Bowel injury.

5. Exacerbation of chronic pelvic inflammatory conditions.

These complications and their accompanying mortality and morbidity, however, may be kept at a minimum by the proper selection of cases for irradiation and proper use of the method. The morbidity in 2634 cases from the literature was 0.3 per cent and the mortality in 8175 cases 0.05 per cent.

#### LATE RESULTS OF TREATMENT

If a total hysterectomy and bilateral salpingo-oophorectomy are performed for the control of menopausal bleeding, the development of genital tract

carcinoma at some future date is eliminated. Should the cervix be left, however, it may be the seat of a malignant growth in later years. In a group of 9325 collected cases this complication of subtotal hysterectomy occurred in 0.64 per cent. Other complications should be minimal in number.

Carcinoma of the uterus may also develop after the establishment of irradiation menopause. In 6883 collected cases, 35 (0.5 per cent) subsequently developed malignancy. Carsaden<sup>3</sup> estimated from his material that patients treated for benign menopausal bleeding are 3.5 times more likely to contract uterine cancer than the normal. Hence it is important that these patients be followed carefully subsequent to treatment and that there be impressed upon them the importance of the immediate reporting of any abnormal vaginal discharge which may develop.

#### SUMMARY

Either hysterectomy or the production of a radiation menopause for the control of climacteric bleeding will produce satisfactory results in properly selected patients and, conversely, either will fail when used where contraindicated. Although irradiation appears on the surface to be the easier of the two, it may result in serious complications when improperly administered.

Although the high incidence of cancer developing in uteri which have been irradiated seems to be a point in favor of total hysterectomy, the immediate mortality rate from the latter procedure is several times higher than from the former and this will nullify any cancer deaths which may occur. These, however, may be kept at a minimum by post treatment observation.

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The organic tradition in medicine has been responsible for a narrow view of the etiology and treatment of essential hypertension. The psychosomatic approach does not neglect the physical problems involved, but includes a consideration of the role of the emotions. It does not mean to study the soma less; it means to study the psyche more. It emphasizes the multiple factors in etiology and pathogenesis and attempts to evaluate the resulting composite clinical picture. Such studies indicate that emotional factors apparently are intimately related to the development of hypertension in some patients, to the production of symptoms in many others, and enter into the question of treatment in nearly all patients with essential hypertension. —Edward Weiss, M.D., and Morris Kleinbart, M.D., in Pennsylvania Medical Journal, September, 1946.

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The possibilities of dissemination of tropical and exotic diseases to the general population of this country by men returning from duty in tropical and subtropical areas of the Pacific has been mentioned in both military and civilian publications. Moreover, the civilian population has been alerted to this possibility, and every effort should be made to study all available data gathered on the subject to date. In most instances it may be safely stated that the possibility of spread is remote. In the majority of parasitic diseases from these areas, the intermediate host or vector either does not exist in this country or is present in insufficient numbers to constitute a definite hazard. In infections where no intermediate host is required, however, as in most intestinal parasitic diseases, a scrutinizing and critical attitude should be adopted so that this subject may be correctly evaluated. —Capt. Paul Michael, MC, USNR, United States Naval Medical Bulletin, October 1946.

## PUBLIC HEALTH ASPECTS OF CANCER CONTROL\*

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Mineola, New York

For many reasons, some obvious, some not, the public health aspects of the control of cancer differ significantly in the State of Kansas and Nassau County, New York.

As you know, I am a native Kansan and a former secretary and executive officer of the Kansas State Board of Health.

Today, I must play two roles. At times, I will be praising the foresight and demonstrated ability of the many pioneers in the Kansas cancer program, including your present very able leader, Dr. F. C. Beelman.

My second character will be that of the coldly analytical appraiser, who points out the deficiencies in the existing set-up and who, for the record, indicates the practicable ways and means of strengthening cancer control in this state.

Until recently, the cancer control program in Kansas consisted essentially of two activities: an educational effort directed at both the laity and the professions and the tabulation, analysis and interpretation of cancer data taken mainly from death certificates. While reporting of cancer has long been a requirement, only a very, very small percentage of cases has been actually reported prior to death. Prior to 1945, no funds were appropriated by the Legislature for use of the Kansas State Board of Health in developing and maintaining a cancer control program. An annual appropriation of \$12,000 for that purpose was made for the biennium beginning 1945.

Morton L. Levin, M.D., director, Division of Cancer Control of the New York State Department of Health, recently made this statement about the Nassau County cancer control program: "There is no similar comprehensive service anywhere else in the state operating through an official health agency."

We make no claim for having an ideal or even completely developed program for cancer control in Nassau County. Aspects of the cancer control program which have been developed there and which I have reason to believe are not carried out in Kansas include: tissue diagnostic service, a community treatment facility, supervision and care of cases by staff public health nurses of the county department of health, and maintenance of a case register.

The highlights in the development of the Nassau County program for cancer control follow:

The Nassau County Medical Society advanced the need for a county hospital in 1922.

A county cancer committee was organized in 1928.

In 1932, the city of New York closed the doors of its municipal cancer treating hospital to non-residents of that city. This was a severe blow to Nassau County residents who needed specialized diagnosis and treatment services as no community facilities were then available in the county for the treatment of cancer.

Since Meadowbrook Hospital (a county-owned and operated general hospital) was being built at that time, obviously a community tumor clinic could not be established in it. Therefore, the Nassau County Tuberculosis Sanatorium, another county-owned and operated institution, set aside an entire floor of one building for temporary use. Necessary x-ray equipment was purchased from the budget of Meadowbrook Hospital and temporarily installed at the sanatorium.

Money for the purchase of a small quantity of radium was secured through private subscription.

Weekly tumor conferences were inaugurated in 1933 and have continued through the succeeding years. These conferences offered an opportunity for group study and discussion of the intricate problems involved in the diagnosis and treatment of tumor growths.

A public health nurse was added to the staff of the Nassau County Cancer Committee in 1933. In due time a qualified medical consultant was selected and assumed his duties as director of the Tumor Clinic.

Nassau County adopted a new charter in 1936 including provision for a county health department which came into being in 1938 to serve the public which now is considerably in excess of 450,000. This single full-time health authority replaced the previously existing 68 part-time health departments. One of the first steps taken by the health department was to district the county for a generalized nursing service to be rendered by its division of public health nursing. In due time a public health nursing council came into existence which brought together all agencies which were rendering public health nursing services.

Meadowbrook Hospital was completed in 1937, and then the Tumor Clinic and all its equipment were transferred there and the work was augmented and improved. Coincident with the transfer, the Tumor Clinic was fully approved by the American College of Surgeons.

\* Read before the First Post-War Conference of the Kansas Public Health Association, at Wichita, Kansas, June 6 and 7, 1946.

\*\* Commissioner, Nassau County Department of Health.

A professional health educator was employed in 1939 by the Cancer Committee.

Many problems, however, continued to exist. There was an urgent need to learn the answers to numerous questions if further progress was to be made in the campaign against cancer. Valuable data existed in New York state, as in the nation, but no method had been devised for collecting it.

Then the 1939 session of the New York State Legislature provided a valuable instrument for the collection of these data. A law was enacted which required the reporting of "cancer and other malignant tumors," effective January 1, 1940. The law was enacted in accordance with the recommendations of the Legislative Cancer Survey Commission in which the medical profession was represented by Dr. James Ewing, Dr. Edward S. Godfrey, Jr., and Dr. Floyd S. Winslow.

In its report the Commission had stressed the need for making use of the experience of all physicians who diagnose, treat or care for cancer patients in gathering data concerning the disease. It was the opinion of the Commission that complete and adequate reporting would provide important information regarding the cancer situation which otherwise could not be obtained and that important information could be secured on the following pertinent points:

1. How much real increase in cancer is occurring? How accurate are mortality statistics? How much cancer is there in the community?
2. Is early diagnosis improving? To what extent is the cancer educational program proving effective in this respect? Is early diagnosis im-

proving more in areas where there is a great deal of cancer education?

3. Is cancer equally prevalent among the different social and economic segments of our population? Is it true, for example, that people of the lower economic grades have more than twice as much cancer of the skin, lip, mouth, larynx and stomach as do people in the higher income classes? If this is true (there is evidence from mortality statistics that it is), what is the explanation?

These, of course, are only a few of the questions to be answered. They are a few which illustrate the importance of cancer reporting, the why of it.

The law requires physicians to report any case considered to be a form of malignant tumor, whether based on x-ray or pathological examination or on purely clinical evidence. Hospitals are also required to report cases, although if the patient is in the hospital when the diagnosis is made, either the hospital or attending physician may submit the report.

The process of reporting is a simple one. It involves filling out a card so designed as to give a maximum of information with a minimum of effort. The physician or hospital reports the case on Form C.C. 1 (Figure 1) which is forwarded to the State Department of Health after office record has been made on Form C.C. 10 (Figure 2). These records, of course, are confidential.

**CASE REPORTING:** A total of 5,330 cases of cancer was registered among Nassau County residents during the six-year period 1940-1945, inclusive.

The high number, 1,133 cases, was recorded in 1940, the first year that reporting of malignant

TOWN VILLAGE CITY	(LEGAL RESIDENCE OF PATIENT)		COUNTY		DIST. NO.		
PATIENT'S NAME: <small>(PLEASE PRINT)</small>			PRESENT AGE:	YEAR OF BIRTH:			
PATIENT'S LEGAL ADDRESS:				SEX:	COLOR:		
USUAL OCCUPATION:	(IF INSTITUTION IN-MATE, GIVE PREVIOUS LEGAL ADDRESS)		MARITAL STATUS:				
Date First Symptom of This Tumor	Date of First Visit for This Tumor to Physician Reporting:		Was Prior Visit Made to Another Physician for This Tumor?				
CLINICAL DIAGNOSIS:							
PATH. DIAGNOSIS		PRIMARY SITE (Tissue of Origin):					
NAME OF PATH. LABORATORY:							
STAGE OF DISEASE		When First Diagnosed: Now:	Early Local <input type="checkbox"/>	Advanced Local <input type="checkbox"/>	Regional Nodes Involved <input type="checkbox"/>	Distant Metastasis <input type="checkbox"/>	Recurrent <input type="checkbox"/>
REFERRED BY: Hospital <input type="checkbox"/> Physician <input type="checkbox"/>						(NAME)	Address or Institution.
REPORTED BY: Physician <input type="checkbox"/>		If Now Hospitalized, Name of Hospital or Institution:			Tumor Clinic <input type="checkbox"/> Patient		
DATE OF THIS REPORT:							

EDWARD S. GODFREY, JR., M.D.  
Commissioner

MALIGNANT NEOPLASM  
CONFIDENTIAL REPORT  
New York State Department of Health  
DIVISION OF CANCER CONTROL

Form C. C. 1 4-25-45-503M (L-112)

Check here if  
you wish more  
reports

Figure 1. Cancer case report form.

neoplasms was required. Naturally, when reporting began, many persons, living in the county and having cancer, were under the care of medical practitioners. That back log, plus the expected annual increment, accounts for the abnormally high number of cases placed on the register in 1940. Second high was 901 cases for the year 1944. The annual average for the six-year period was 883 cases.

Case rates per 100,000 ranged from a high of 278.5 in 1940 to a low of 166.2 in 1943. Last year 196 cancer cases among residents were reported for each 100,000 population. The average case rate for the six-year period was 198.3. See Table 1.

Table 1—Cancer cases and deaths registered by years, for the six-year period, 1940-1945, inclusive; with rates per 100,000 population, Nassau County, New York.

Year	Cases		Deaths	
	Number	Rate	Number	Rate
1945	899	195.8	734	159.9
1944	901	198.8	684	150.7
1943	774	166.2	626	134.4
1942	794	168.2	648	137.3
1941	829	192.7	578	134.3
1940	1133	278.5	564	138.6
Average	883	198.3	639	142.6

**REPORTS BY SOURCE:** Physicians in private practice during the six years submitted 3,310 case reports or 62.1 per cent of all registered cases. The remainder, 2,020 cases, was reported by the Tumor Clinic, or from private hospitals. As was anticipated the Tumor Clinic reported an exceptionally high

number of cases, 543, or 47.9 per cent, during the first year the reporting law was in effect.

During the six-year period that reporting has been required, the Tumor Clinic has been the source of from 22.1 to 50.3 per cent of the cases reported. Since 1941, of all cases reported by years, the Tumor Clinic has accounted for a progressively increasing percentage. This fact reflects the value of the Tumor Clinic as a case finding facility.

Cases reported by source will be found in Table 2.

Table 2—Cancer case reports by source during the six-year period 1940-1945, inclusive; Nassau County, New York.

Year	Physicians		Tumor Clinic and hospitals	Reported by	Total
	Number reporting	Cases reported			
1945	180	446	453		899
1944	200	534	367		901
1943	194	522	252		774
1942	353	572	222		794
1941	238	646	183		829
1940	217	590	543		1133
Total	.....	3310	2020		5330

In 1946, the Nassau County Cancer Committee set a goal in its fund raising campaign of \$75,000, of which \$45,000 will be used to establish and maintain a nursing home for cancer patients. This home will actually be in operation before the end of this year.

As recently as May 28, 1946, the Nassau County Medical Society adopted a resolution to be sent to the County Executive, setting forth the need for a

county-operated hospital for chronic diseases to be constructed on the Meadowbrook Hospital grounds.

As a whole, Nassau County physicians have made an excellent response to the requirement of cancer reporting. During 1940 and 1941, receipt of the certificate of death was the first notice of cancer in 3 of each 10 cases registered in those years. During the three years of war, there was a decrease in the promptness of cancer notification and it was necessary to make a request to the attending physician for reports of 4 of each 10 cases registered during this period. The work of the department, in connection with cancer reporting alone, was increased 33 per cent during the war years due to the fact that the percentage of requested reports jumped from 30 pre-war to the present 40.

Essential information was omitted from a substantial number of reports. In many instances this was due to the failure of the reporting physician to include on Form C.C. 1, necessary data which were contained in the patient's history filed in his office. It was then necessary either to write a letter, make a telephone call or make a visit to his office. Pertinent data most often omitted concerned the date of onset, the first visit to a physician, or designation of the specific site attacked by the cancerous growth.

Were every physician to obtain and record a complete history on all cancer patients, the information gained from analysis would be of even greater value to the practitioner than the present analysis.

**CASES BY COLOR:** A total of 5,206 cases was recorded among white persons and 124 cases among colored persons. Reported incidence of cancer among colored persons was 2.3 per cent, whereas the colored population is five per cent of the total county population.

**CASES BY SEX AND AGE:** By sex, reported cancer predominated among females, who accounted for 2,888 cases compared with 2,442 malignancies among males. While cancer occurs at any age, 19 of each 20 cases (95.4 per cent) were registered among persons 35 years of age and over. Malignancies in individuals in the age group 34 and under are most commonly bone tumors (osteogenic sarcoma, Hodgkin's disease and the leukemias.)

Females from birth to 55 years of age account for a significantly higher proportion of cancer cases than do males; from 55 years on the sexes are attacked equally. (See Table 3). Malignant tumors of the uterus and the breast are responsible for the inequality in attack rates by sexes in the younger age groups.

Statistical particulars of all cases reported by site, sex and certain age groups during the six-year period, 1940-1945, inclusive, will be found in Table 4.

**AGE AT ONSET:** Information concerning either

year of onset or age at onset of the malignancy was supplied in 75 per cent of the reported cases. The average age at onset for males was 60.8 years and for females 57.7 years. The average age at onset for both sexes was 58.1 years. The youngest reported case was in a baby of one month; the oldest in a man of 98 years.

Table 3—Cancer cases reported by sex and certain age groups during the six-year period 1940-1945, inclusive; Nassau County, New York.

Age groups in years	Total	Reported cases by sex			
		Number	Male Per cent	Female Number	Per cent
All groups	5330	2442	45.8	2888	54.2
0-34	232	85	36.6	147	63.4
35-44	498	154	30.9	344	69.1
45-54	1049	400	38.1	649	61.9
55-64	1356	688	50.7	668	49.3
65-74	1353	670	49.5	683	50.5
75 and over	842	445	52.9	397	47.1

**CASES REPORTED BY SITE:** Cancer of sites obviously accessible for tissue examination and to treatment by surgery, x-ray or radium might be assumed to have a more favorable prognosis than malignancies of sites which are inaccessible for tissue examination without surgical exploration. These data are in Tables 5 and 6.

Only 581, or 42.6 per cent of 1,364 cases of cancer involving either the buccal cavity and pharynx, the vagina, the vulva, the breast, the scrotum, the testes, the penis, the skin or the thyroid gland were dead as of January 1, 1945. A total of 1,759, or 83.0 per cent of 2,119 cancer cases having as their primary sites either the digestive organs and peritoneum (except esophagus, rectum and anus), the respiratory system (except larynx), the uterus when cervix was not specified as the site, other female genital organs (except vagina and vulva), the urinary organs (except bladder), the brain and central nervous system, or unspecified sites (excepting Hodgkin's disease and leukemias) were dead as of January 1, 1945. Cancer of sites which can be reached for tissue examination only through the use of special instruments, but without necessarily employing surgical exploration, have a prognosis intermediate between the other two groups.

Obviously accessible sites were involved in 31 per cent of all reported cases. Sites which are accessible for tissue examination only through recourse to surgery were attacked in 48 per cent of all cases.

The principal sites when grouped under general headings are in order: digestive organs and peritoneum, 1,706; breast, 761; skin, 522; uterus, 493; respiratory system, 358; male genital organs, 258; urinary organs (male and female), 256; buccal cavity and pharynx, 255; and other female genital organs, 205.

**TISSUE EXAMINATIONS:** Precision methods of diagnosis are available for use in determining the probable presence or absence of cancerous growth in tissue. A biopsy, the diagnostic examination of a piece of tissue removed from a living subject, done promptly and expertly, can mean the difference between life and death for those who have cancer. The laity quite generally knows that removal of a portion of a lump or growth on the surface of the body

can be quickly accomplished with very minor surgery. The layman too often is uninformed or unconvinced of the ability of the physician to perform a biopsy on some of the unexposed parts of the body by doing no more "cutting" than would be required were the tumor on the skin surface. Unfortunately, not all people know that many of the tubular structures' inner linings can be seen through instruments which can be inserted through natural openings of

Table 4—Cancer cases reported by site, sex and certain age groups during the six-year period, 1940-1945, inclusive; Nassau County, New York.

Code No.	Primary site	Sex	All cases	0-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75 & over
	All cases	M&F	5330	28	22	16	39	127	498	1049	1356	1353	842
		M	2442	11	12	9	17	36	154	400	688	670	445
		F	2888	17	10	7	22	91	344	649	668	683	397
45.	Cancer of the buccal cavity and pharynx	M&F	255	0	0	0	0	4	23	53	74	62	39
		M	217	0	0	0	0	2	21	44	65	56	29
		F	38	0	0	0	0	2	2	9	9	6	10
46.	Cancer of the digestive organs and peritoneum	M&F	1706	1	0	0	1	9	84	260	488	518	335
		M	909	0	0	0	0	5	44	141	290	260	169
		F	897	1	0	0	1	14	40	119	198	258	166
47.	Cancer of the respiratory system	M&F	358	0	1	1	0	5	18	90	111	89	43
		M	297	0	1	1	0	5	14	79	96	69	32
		F	61	0	0	0	0	0	4	11	15	20	11
48.	Cancer of the uterus	F	493	0	0	0	1	17	95	130	134	84	32
49.	Cancer of other female genital organs	F	205	0	0	0	1	7	32	71	49	32	13
50.	Cancer of the breast	M&F	761	0	0	0	1	17	117	217	170	159	80
		M	9	0	0	0	0	0	1	1	5	2	0
		F	752	0	0	0	1	17	116	216	165	157	80
51.	Cancer of the male genital organs	M	258	0	0	0	0	7	14	16	44	94	83
52.	Cancer of the urinary organs (male and female)	M&F	256	6	1	0	1	4	9	33	65	81	56
		M	179	4	1	0	0	0	6	20	50	61	37
		F	77	2	0	0	1	4	3	13	15	20	19
53.	Cancer of the skin (except vulva and scrotum)	M&F	522	0	1	1	3	13	41	79	112	151	119
		M	305	0	0	1	1	6	23	44	75	88	67
		F	217	0	1	0	2	7	18	35	39	63	52
54.	Cancer of the brain and other parts of c.n.s.	M&F	64	1	2	3	6	2	12	17	14	5	2
		M	36	0	1	1	1	0	6	10	12	3	2
		F	28	1	1	2	5	2	6	7	2	2	0
55.	Cancer of other and unspecified parts	M&F	452	20	17	11	25	32	53	83	93	78	40
		M	232	7	9	6	15	11	25	45	51	37	26
		F	220	13	8	5	10	21	28	38	42	41	14

Table 5—Reported cancer cases for the six-year period, 1940-1945, inclusive, by primary site grouped according to the International List of Causes of Death—for those known to be dead and for those presumably alive on January 1, 1946; Nassau County, New York.

Code No.	Primary cases	Registered cases			
		Total	Known to be dead	Presumably alive	Per Cent alive
All sites		5330	3738	1592	29.8
45. Buccal cavity—pharynx		255	126	129	50.5
46. Digestive organs—peritoneum		1706	1501	205	12.0
47. Respiratory system		358	322	36	10.0
48. Uterus		493	282	211	42.7
49. Other female genital organs		205	163	42	20.4
50. Breast		761	453	308	40.4
51. Male genital organs		258	201	57	22.0
52. Urinary organs (male and female)		256	198	58	22.6
53. Skin		522	83	439	84.0
54. Brain—central nervous system		64	62	2	3.1
55. Other and unspecified parts		452	347	105	23.2

the body. For example, the inside of the gullet can be seen by passing a special instrument into it through the mouth. In a similar manner, the inside of the bladder, the voice box, the rectum, the neck of the uterus and other structures can be viewed, and, if indicated, a piece of tissue can be removed for examination.

Laymen and physicians alike are interested in the answers to questions such as the following:

Of each 100 reported diagnoses of cancer how many are based on tissue examinations made during the lifetime or after death of the individuals?

Does the probability of diagnosis based on biopsy or necropsy differ significantly depending on the primary site of the malignancy?

Data which could supply partial answers to those questions are available for the three-year period 1942-1944, inclusive, and are contained in Table 7 and Table 8.

For that period, 6 of each 10 diagnoses of cancer

were based on findings of tissue examinations, copies of which were filed with the county department of health.

For cancers primary in tissues of the buccal cavity, breast and skin, the per cent of recorded tissue examinations was 67.8. The per cent of cases having biopsies and/or necropsies for malignancies beginning in all other parts of the body was 58.6.

The likelihood of a tissue examination being recorded was greatest for malignancies of the buccal cavity and pharynx, 78.3 per cent.

The smallest proportion, 48.7 per cent, of tissue examinations recorded was for cancer of the digestive organs and peritoneum.

The median per cent of recorded biopsies and necropsies was for cancer of the breast, 68.0 per cent.

Since tissue is equally readily accessible for examination when a new growth involves either the skin, breast or buccal cavity, one would expect that the ratio of biopsies to cases would be of the same

Table 6—Reported cancer cases for the five-year period, 1940-1945, inclusive, by accessibility of primary sites to biopsy for those known to be dead and for those presumably alive on January 1, 1945; Nassau County, New York.

Table 7—Proportion of recorded tissue examinations to reported cases by primary site, by years for the three-year period, 1942-1944, inclusive, showing range and average; Nassau County, New York.

Code No.	Primary site	Proportion recorded tissue examinations to reported cases					
		Average	Range	High year	Low year	1944	1943
45.	Buccal cavity—pharynx	78.3	73.5—82.0	1943	1944	73.5	82.0
50.	Breast	68.0	65.0—69.6	1942	1943	68.9	65.0
53.	Skin	62.4	43.2—73.0	1942	1943	70.1	43.2
Total		67.8	60.5—72.0	1942	1943	69.9	60.5
48.	Uterus	75.1	71.6—77.0	1944	1943	77.0	71.6
51.	Male genital organs	67.5	62.5—71.4	1942	1944	62.5	70.0
46.	Digestive organs, peritoneum	48.7	45.2—55.0	1944	1943	55.0	45.2
47.	Respiratory system	50.9	41.3—60.0	1943	1942	51.4	60.0
49.	Female genital organs	71.5	68.4—75.0	1942	1944	68.4	71.4
52.	Urinary organs	72.9	72.0—74.3	1942	1943	72.7	72.0
54	Brain and Central Nervous	75.7	66.6—85.7	1942	1943	76.4	66.7
55.	Other and unspecified parts	63.8	50.0—72.5	1944	1943	72.5	50.0
Sum of 48 & 51	Uterus, Male genital organs	72.5	71.0—74.7	1942	1943	71.9	71.0
Sum of 46, 47, 49, 52, 54, 55	All others	55.6	51.8—60.5	1944	1943	60.5	51.8
Total of 48, 51, 46, 47, 49, 52, 54 and 55	All others than buccal breast skin	58.6	55.3—62.5	1944	1943	62.5	55.3
Total 45 through 55	All sites	61.2	56.7—64.5	1944	1943	64.5	56.7

Table 8—Percentage of tissue examinations by sites listed in ascending order for the three-year period, 1942-1944, inclusive; Nassau County, New York.

Code No.	Primary site	Per cent examinations
46.	Digestive organs and peritoneum	48.7
47.	Respiratory system	50.9
53.	Skin	62.4
55.	Other and unspecified organs	63.8
51.	Male genital organs	67.5
50.	Breast	68.0*
49.	Female genital organs	71.5
52.	Urinary organs	72.9
48.	Uterus	75.1
54.	Brain and central nervous system	75.7
55.	Buccal cavity and pharynx	78.3
All sites		61.2

\*Median

order for those sites. The recorded experience for Nassau County does not support that assumption. This study shows that the diagnosis of skin, breast and buccal cancer is not based on recorded tissue examination in respectively 4, 3, and 2 out of each 10 registered cases.

The need for having tissue examinations made on all obviously and readily accessible new growths is accepted by all. This study shows that the precision method diagnosis (biopsy—necropsy) is not utilized in 100 per cent of cases involving cancer of accessible sites. This failure to achieve an admittedly desirable goal gives cause for reflection. Why and how does performance fall short of theoretic possibilities?

CANCER NURSING: In 1940, prior to the initiation of cancer nursing as a part of the general

public health nursing program, scientific lectures were arranged to equip the nurses for their three-fold task: (1) to teach cancer prevention and to urge prompt medical care when indicated; (2) to interpret instructions to patients for the clinic and private physician and teach them how to care for themselves or demonstrate and supervise care given by other persons; and (3) to give nursing care when necessary.

During 1940 one out of each 14 cases reported was referred for nursing care. In 1941 one out of four reported was referred. It is to be noted that this represents the only full pre-war year of service. In 1943 the ratio was one to six and in 1944 one to eight cases referred. While this ratio is not high, there are no known data indicating such service available to this extent in other places throughout the country.

Of the 624 cases referred during 1940-1944, inclusive, 541 were referred by the Tumor Clinic at Meadowbrook Hospital in contrast to 47 by private physicians. The remaining 36 were referred by other agencies or individuals. There were 379 malignant and 245 benign cases. The latter is indicative of the preventive service rendered.

A total of 6,087 nursing visits was made to all cases during the five-year period, 1940-1944, inclusive. Of course, 2,098 were to persuade patients to return to clinic for treatment or examination. If this relatively high proportion of visits could be reduced, it would allow more actual service for those patients who need it most.

In 63 instances, during the five-year period, patients were taught to care for themselves, and in 162 others some other person was taught and supervised in giving care. The greatest number of visits in relation to the number of months patients were under care was 1,368 to those under care from one to two years. A small fraction, one fourteenth, of these visits were to give terminal care. The second largest number, 787, were to those under care from one to three months. Of these more than half were terminal care visits.

The highest number of visits to a single patient was 160 made to a woman with cancer of the rectum, over a period of 20 months. The husband was taught to give care with frequent help from the nurse. In another instance 144 visits over a period of 12 months were made to a cancer of the sigmoid to give terminal care and supervise that given by the mother-in-law.

The greatest number of cases referred in any one year was 204 in 1941; the lowest was 86 in 1942. The effects of the war are noted in these figures. There were 114 cases referred in 1944.

The important ways that the cancer control program in the two areas, the State of Kansas and Nassau County, New York, agree and differ are shown in Table 9.

In each governmental unit, cancer ranks as the second cause of death. The mortality rates are com-

parable. The recorded incidence by sex does not differ significantly. In both areas reported cancer predominates among females. The percentages of registered cases among persons 55 years and over are practically identical. Cancer of the three obviously accessible sites, buccal cavity, breast and skin, have almost the same frequencies of reported occurrence by sex. In each area, cancer of the skin is reported among males twice as often as among females. For every malignant tumor of the breast recorded for males, 80 are registered for females. The ratio of reported cancer of the buccal cavity, males to females, is six to one.

Significant differences in the cancer control program of the two political subdivisions may be summarized as follows:

Reporting of malignant tumors is much more complete in Nassau County than in the State of Kansas. An even more important difference in reporting is the fact that in Nassau County 60 per cent of the cases are known to the official health agency before death, while in this State, according to Dr. F. C. Beelman, "a high per cent of the cases are not being reported prior to the filing of the death certificate."<sup>2</sup> Each year in Nassau County reported cases exceeded recorded deaths by 50 per cent, while in Kansas about one case is reported for every 10 deaths assigned to cancer.

Every public health administrator appreciates the

Table 9—Comparisons in cancer incidence and important cancer facilities in the State of Kansas and Nassau County, New York.

Item	State of Kansas	Nassau County, New York
Population .....	1,800,000	460,000
Death rate per 100,000 (1943) .....	127.0	134.4
Rank as cause of death.....	Second	Second
Reporting .....	Required—no special report card	Required—special report card
Case reports:		
Years 1940-1943 .....	860 cases	3,530 cases
Annual average .....	215 cases	882 cases
Case reports prior to death.....	High per cent not filed	60 per cent filed before death
Ratio cases/deaths .....	One to 10	Fifteen to 10
Evidence of improved reporting.....	None—range 69 (1935 and 1936) to 312 (1925)	Average: 1942-1943—784 cases 1944-1945—900 cases
By sex .....	Male 46.7%—Female 53.3%	Male 45.8%—Female 54.2%
By age (55 years and over). .	89.8 per cent	86.2 per cent
By accessibility of site:		
Skin, buccal cavity, breast, male and female genitals .....	32.2 per cent	43.2 per cent
Buccal cavity .....	3.6 per cent (M-4 X F)	4.7 per cent (M-6 X F)
Breast .....	8.7 per cent (F-80 X M)	14.2 per cent (M-84 X M)
Skin .....	3.5 per cent (M-2 X F)	9.7 per cent (M-2 X F)
Digestive tract .....	50.7 per cent (M-53.2%)	32.0 per cent (M-53.2%)
Public laboratory diagnostic facilities:		
State .....	??	Available
Local .....	??	Available
Public clinical diagnostic and treatment service .....	?	Available
Public health nursing service as a function of the official public health agency .....	?	Available
Cancer nursing home .....	?	To be established in 1946
Chronic disease hospital .....	?	Proposed
Appropriation of public funds .....	\$12,000 annual	\$10,000 annual (estimated)

fact that no disease can be controlled until accurate information is available concerning where, when and under what conditions the malady occurs. Only through reporting can the answers to those and many equally important questions about cancer be obtained. Only through early and complete reporting can the available community resources be brought to bear full force in saving lives and alleviating unnecessary suffering.

To achieve the objective of early and complete reporting of cancer, the same administrative techniques and practices that are used for tuberculosis must be employed. A special report card is required. The information contained on the report card must be confidential. Under the direction of a qualified medical public health officer, data missing from records must be requested and secured. Physicians must be asked to file a belated case report for all persons for whom the death certificate is the first notice of cancer. A case register must be set up and kept current. Every death certificate for a resident whose age at death is 35 or over should be checked against the case register. Only if this procedure is followed will a sizeable number of deaths annually due to cancer be assigned.

Were case reporting in Kansas to equal in completeness that prevailing in Nassau County, new cases each year would number no less than 3,600. A minimum of four full-time clerks would be required to handle the cancer case register. In addition stenographic service would have to be provided. The volume of cancer case reports handled will likely more than double those for tuberculosis.

Unlike tuberculosis, cancer is not contagious. However, the control of cancer, like the control of tuberculosis, depends first upon its detection in the earliest demonstrable stage, and secondly upon the immediate and effective use of the curative measures of choice. Case finding and case holding in both diseases require community action and facilities.

The public facilities that Nassau has provided, Kansas must also establish and maintain if the many sufferers from cancer are to have the benefits of early diagnosis, effective treatment, and professional supervision and care.

A cancer nursing service should be a part of the generalized public health nursing service available to all the people. Such a nursing service is an essential activity of a local full-time health department which both the medical profession and public health officials agree needs to be established and maintained to serve the people. Sixteen such local full-time health departments now operate in Kansas. Such local health units must be provided for all the people of this state.

Kansas has already provided public laboratory and

clinical diagnostic services for tuberculosis, and government operated sanatoria for the treatment of tuberculous individuals. Kansas must now do as Nassau County has already done—provide comparable services and facilities for cancer diagnosis and treatment financed by public funds to whatever extent such support is necessary.

The public and the professions upon whom the people rely for cancer diagnosis, treatment and care must have the opportunities of an educational program. Education alone is not sufficient. Necessary diagnostic and treatment facilities must also be available. In fact, without the latter, learning cannot occur.

In Nassau, the Cancer Committee, a voluntary health agency supported by the people's subscriptions, has pioneered. It has explored new channels of service. Through its efforts, these new areas of service have been established to be economically feasible and meaningful to the public and the professions. Then it has helped to secure the maintenance and further necessary development of those services through public funds and the official health agency.

Within the limitations of its financial support, the Cancer Committee of the Kansas Medical Society has done and will continue to do likewise.

#### SUMMARY

1. Cancer is a public health problem second in importance only to diseases of the heart.
2. The same techniques and procedures which have so effectively brought tuberculosis and syphilis under control must also be expertly applied in cancer control. The necessary elements are: (1) a division or section of cancer control within the official health agency; (2) a requirement of law to report cases to the health department; (3) a system of follow-up to maintain and use effectively a confidential case register; (4) provision for public supported laboratory service, including tissue examinations and cancer research; (5) establishment and maintenance with public funds, to the extent necessary, of tumor diagnostic and treatment facilities sufficient in number and accessible to the people; (6) coverage of the state by local full-time health departments providing thereby a generalized public health nursing service, including cancer nursing; (7) provision for necessary hospital beds to care for chronic diseases, including cancer; (8) strengthening of the educational program to achieve the objective of learning through participation; (9) continuation of joint voluntary and official health agency effort in the exploration of new channels of service.

Those in Kansas who have pioneered in public health have achieved much and are the first to recognize the strength and weaknesses of the existing program for cancer control. Through the intelligent

and tireless efforts of men and women, living and dead, have come advances such as the recently made specific appropriation for cancer control. Such understanding and intelligent action by the peoples' chosen representatives deserves the highest possible commendation. May such legislators continue to serve and provide even more liberally the necessary

financial support for cancer control. The legislators of Kansas will not fail their constituents. Sufficient public moneys must be provided for all public health work.

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## RIEDEL'S LOBE OF THE LIVER—REPORT OF CASE

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Few cases of Riedel's lobe of the liver are reported in the literature and those that are recorded usually show an error in diagnosis preoperatively. The case here reported demonstrates the possibility of error in diagnosis before operation.

The lobe was originally described in 1888 by Riedel<sup>6</sup> as a linguiform lobulation or tonguelike prolongation of the anterior margin of the right lobe of the liver. This process is attached to the liver proper either by a small bridge of hepatic tissue, or occasionally by merely fibrous tissue. Although one anatomist writing in the early eighties said that Riedel's lobe occurred in as high as 30 per cent of women over 40, but in only 15 per cent of men, the condition is rarely seen today. In the department of anatomy at Washington University Medical School, not a single case was seen in the period of five years extending from 1918 to 1923.<sup>7</sup>

The presence of this lobe has been ascribed to a variety of causes: gallstones with enlarged gall bladder, tight-lacing in corsets, syphilitic perihepatitis with scarring of the liver and partial or local ptosis of the liver. The exact mechanism leading to the formation of this lobe is often obscure.<sup>1</sup> Riedel was an advocate of gallbladder traction and considered the condition due to the gradual enlargement of the gallbladder which in turn pushed the liver lobule downward. Since his original article several cases have been reported of the condition occurring in young infants and in patients with no evidence of cholecytic disease or stones. Tight-lacing of the abdomen in a corset produces the "corset liver" which can be distinguished from Riedel's lobe in that the elongated process is separated from the liver proper by merely a dense fibrous band, while in cases of Riedel's lobe the connection seems to be true hepatic tissue.<sup>7</sup> Syphilitic perihepatitis is a doubtful cause; the more logical answer being that the specific disease occurs in a liver that is the subject of a congenital irregularity of the lobes, the presence of which is discovered by the necessary clinical examination.<sup>4</sup> Syphilitic cirrhosis and dense scarring of the liver

tissue have been reported on numerous occasions, yet no Riedel's lobe has been seen. Careful distinction between a well-defined Riedel's lobe and the tendency of the right lobe of the liver to protrude low down into the abdomen in partial or local ptosis of the liver should be made. "In the latter case the tumour has a large broad base at its liver attachment, is not so freely moveable, and has not the striking similarity to a distended gallbladder or moveable right kidney which characterizes the congenital Riedel's lobe with its narrow attached end, and its rounded polypus-like extremity."<sup>4</sup>

Riedel's lobe of the liver rarely causes symptoms of itself. It may occasionally cause a dull dragging discomfort in the right upper abdomen, or even cause attacks of sharp pain similar to biliary colic. When present the pain is usually the result of co-existing gallbladder disease. If the pedicle of Riedel's lobe becomes twisted the lobe may undergo degenerative changes. The liver tissue is frequently the site of fibrosis or of repeated hemorrhages.<sup>1</sup>

In the majority of recorded cases this adventitious lobe has been mistaken for a moveable right kidney or an enlarged gallbladder, due to a stone blocking the cystic duct. Rarer possibilities for error in diagnosis include retroperitoneal tumor or even an appendiceal abscess or uterine myoma.

Physical examination usually reveals a tongue-like mass appended to the liver and moving with the organ on respiration. The mass may extend quite low into the abdomen. Conceivably the lobe may buckle upon itself on deep respiration and thereby give the impression that the mass does not move on respiration. Again the upper border may not be felt to merge into the liver proper. Synchronous movements of the mass and the liver with respiration may not be of assistance if the liver proper does not extend below the costal margin on deep inspiration. Differentiation from a distended gallbladder may likewise be very difficult. Usually the distended gallbladder imparts a definitely cystic feel on palpation and is well rounded, whereas a Riedel's lobe if

distinctly palpated is generally found to have a sharp and somewhat firm lower edge.<sup>1</sup>

The prognosis is good in these cases and the correct diagnosis often leads to great satisfaction on the part of the clinician since it eliminates the possibility of malignancy. Operative interference is scarcely justifiable if the correct diagnosis can be made preoperatively. However, this is rarely possible without abdominal exploration. If examinations indicate the presence of gallbladder disease and pain is being produced, cholecystectomy should be done.<sup>1,4</sup> Disappearance of a Riedel's lobe after a cholecystectomy has been reported.<sup>5</sup> In the absence of cholecytic disease proper abdominal support may occasionally relieve the discomfort produced.<sup>1</sup>

#### REPORT OF CASE\*

B. S., a housewife, age 63, was admitted to the hospital (7/11/46) complaining of a "lump in my stomach." She first noticed this lump approximately one year before admission. The only symptom she had noticed was a slight "hurting" in the mass after exertion. Her past history was negative except for an attack of typhoid fever without complication 30 years ago. She had had no operations or serious accidents. Her family history was non-contributory. Systemic review revealed no history of dyspnea, chest pain, palpitation, edema, cough or hemoptysis. Her appetite was good; she had been obese for years with no recent weight loss; she had had no nausea, vomiting, jaundice or melena. She had been constipated for years with no change in bowel habit, calibre of stool or alternating periods of constipation and diarrhea. She had no symptoms referable to the urinary system. Menstruation began at 12 years, stopped at 42 years, periods were always regular at 28-day intervals and flow lasted 3-4 days. She had had no postmenopausal bleeding or discharge. She had two pregnancies, both full term normal deliveries.

Physical examination on admission: T=98.8°; P=72, full and regular; R=16, regular; B.P.=105/75. General inspection revealed a well-developed, obese, white female of stated age who did not appear acutely or chronically ill. Skin texture was good with no lesions or jaundice. Eyes, ears, nose and throat negative. Edentulous. No cervical adenopathy; thyroid not palpable. Breasts negative. Thoracic cage moved symmetrically on respiration. The PMI was within normal limits, heart sounds well differentiated and regular, no murmurs heard or thrills palpated. The lung fields were resonant; no abnormal sounds ausculted. The abdomen was obese with no rigidity, distension or tenderness. There was a palpable, non-tender, firm mass approximately 8

cm. in diameter in the right iliac and hypogastric regions. The edges of the mass were ill-defined. Several examiners felt the mass did not move with respiration. The liver, kidneys and spleen were not palpable. Extremities were negative. Pelvic examination revealed a chronic cervicitis with a small erosion. Rectal examination was negative.

Laboratory examinations showed an acid urine with specific gravity of 1.007, 10-20WBC/hpf (uncatheterized specimen), a few renal casts and a few squamous epithelial cells; albumin and sugar negative. Blood examination: Hemoglobin, 79%; RBC 4,260,000; WBC 5,300; Differential: segmented neutrophiles 54, stab forms 4, juvenile forms 4, eosinophiles 2 and lymphocytes 36. Color index was 0.93 and the coagulation time was 3½ minutes. Blood levels of sugar and non-protein-nitrogen were within normal limits. Blood serology negative.

Intravenous pyelography one month before admission to the hospital revealed no evidence of pathology in the genito-urinary tract. Barium enema showed the colon outlined throughout its whole course with a "definite depression downward of the hepatic flexure; no evidence of any intrinsic involvement in the colon." Barium enema repeated two days later gave the impression "that there is no definite pathology within the colon." The roentgenologist reached the conclusion "throughout this entire examination there is this large mass on the right side that apparently is not the kidney and after a complete study of all these negatives, I am inclined to believe that it is not the liver. We are probably dealing with a retroperitoneal mass of some type."

A preoperative diagnosis of right retroperitoneal tumor was made. On 7/12/46 under cyclopropane anesthesia a right transverse incision was made and the abdomen explored. Both kidneys, spleen, sigmoid and transverse colon, uterus, tubes and right ovary were negative. The left ovary contained several small cysts. There were no palpable mesenteric nodes. The right and left lobes of the liver were normal in size, shape and position. There was a tonguelike projection from the right lobe which extended into the right pelvis and was connected with the right lobe by a small band composed largely of normal liver tissue with a small amount of fibrous tissue. The gallbladder was attached to the inferior medial surface of the projection in the right pelvis. There was no gross pathology of the gallbladder. A small biopsy was taken from the projection. The pathologist reported: "Moderate hemorrhagic congestion of the liver with no evidence of malignancy." The patient's post-operative course was uneventful.

#### COMMENT

This case of Riedel's lobe of the liver confirms the difficulty one may experience in accurate pre-

\* From the services of Drs. D. R. Black and J. G. Montgomery, Research Hospital, Kansas City, Mo.

operative diagnosis even after careful clinical studies and examinations have been made. The gross appearance of the liver at operation unquestionably makes the diagnosis of Riedel's lobe correct. The patient's history was typically that of a Riedel's lobe but other possibilities could hardly be eliminated. Although clinically the patient did not appear to have a malignancy the physical examination was confusing. In retrospect it seems the Riedel's lobe and its connection with the right lobe of the liver proper buckled anteriorly on deep inspiration thereby giving the impression to the palpating hand of no movement on respiration. The inferior border of the right lobe did not extend below the costal margin on deep inspiration hence the usual criterion of synchronous movement of the mass and the liver on inspiration could not be applied. Likewise the upper border of the mass was so ill-defined that it could not be felt to merge the liver proper. Fortunately there were no symptoms referable to the right genitourinary tract to confuse the picture. The pathological change in the hepatic tissue in this Riedel's lobe was most likely due to impaired arterial and venous circulation through the pedicle.

Cancer can neither be diagnosed nor treated successfully without cooperative effort. Probably no other disease requires so much cooperation from so many people and from such a variety of people as does this number two cause of death.

The commonly accepted dictum "no cancer diagnosis is complete without pathologic confirmation" immediately establishes the idea of the "team" in diagnosis. The patient usually is first seen by the family physician, a general practitioner. If cancer is suspected, help must be sought from one or more of the specialist group. The general surgeon or the surgeon in some special field, the roentgenologist, and finally the pathologist and his technician, all are called upon to play a part. This teamwork becomes increasingly important as the educational efforts of the official and voluntary health agencies succeed in bringing to the physician's office an increasing percentage of curable cancers. Cancer which can be diagnosed merely by the history or by a simple examination is seldom curable cancer; the diagnosis of early cancer requires teamwork.

This observation is equally true in the case of cancer therapy; the surgeon and the radiologist must help the internist. More than that, cancer surgery is more and more becoming radical surgery and there is a growing tendency for cancer specialization even within the fields of the several surgical branches. It is a growing recognition of these facts which is resulting in the creation of special cancer services in general hospitals and in the establishment of special cancer hospitals.

The need for this clinical teamwork is well known to all physicians; it is mentioned at this time merely to lend emphasis to two points. First, that there is another member of this clinical team whose importance is sometimes overlooked, and second, that the clinical team is not the only team needed in cancer control.

The overlooked member of the clinical team is the pa-

## SUMMARY

Riedel's lobe of the liver should be considered in the differential diagnosis of masses in the right abdomen. Unfortunately the correct diagnosis may not be possible preoperatively even after careful history-taking, physical examination and roentgen ray studies. Treatment is simple; surgery may be indicated to establish the diagnosis and eliminate the possibility of retroperitoneal malignancy or pathology of the right kidney or right colon. Cholecystectomy is in order if the gallbladder is diseased and/or pain is a prominent symptom. A case of Riedel's lobe of the liver is reported.

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tient himself. Regardless of the excellence of the diagnostic and treatment skills and facilities available in any community, with the sum of our present knowledge no one can hope to cure patients suffering from advanced, disseminated, generalized cancer. Cancer to be curable must be localized cancer; localized cancer is usually early cancer; seldom does the physician see early cancer unless it is brought to him by the patient himself; and the patient cannot be expected to seek help for early cancer unless that patient has been instructed, unless he knows what to look for, what to be suspicious of, and what he can hope for if he reports promptly to his physician for medical advice.—J. Louis Neff, M.D., Texas State Journal of Medicine, September 1946.

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The usefulness of hepatosplenography resides in the reliable demonstration of the size of the liver and spleen, and their internal architecture. In this way it is possible to solve important diagnostic therapeutic problems such as the presence or absence of abscess, cirrhosis, or tumor, and often to differentiate between these. One may also follow the progress of healing of a cavity or tumor metastasis under treatment. There is apparently no more reliable laboratory method short of operation to differentiate between carcinoma and cirrhosis in an enlarged liver. It is no small comfort to a surgeon to know the exact location of a liver abscess, its size, and relations, before drainage is attempted.

Pyogenic abscess is primarily a complication of an intra-abdominal suppurative process with the causative organism in the portal area. Of these lesions appendicitis is the most frequent. The most frequently found organisms in the pyogenic hepatic abscesses are *B. coli*, and *Staphylococci*. Amebic abscess is the most common cause of liver abscess in our study.—Robert J. Reeves, M.D., and Karl A. Youngstrom, M.D., Texas State Journal of Medicine, September 1946.

## EDITORIALS

### Medicine Under Federal Control

High schools and colleges throughout the United States have this year been assigned for debate the subject of compulsory health insurance. The actual debate question is as follows: Resolved: that the Federal Government should provide a system of complete medical care available to all citizens at public expense.

Debaters in every school will be searching for material, and certainly there is no dearth of information presenting the positive side of this question. On the negative argument the National Physicians Committee has issued a book entitled "Compulsion—the Key to Collectivism," summarizing arguments presented during the Senate committee hearings. The A.M.A. Council on Medical Service has recently issued a booklet entitled "Voluntary Health Insurance versus Compulsory Sickness Insurance," giving much statistical information. A second handbook is now in preparation and should be distributed in the near future.

This presented an opportunity to the Kansas Medical Society to express the views of the medical profession in Kansas. It is contemplated that the following articles by the presidents of three organizations vitally interested in medical care shall be combined into a handbook to be distributed to all high schools and colleges in this state. It is published here to give the medical profession advance information concerning a portion of the public relations program as carried on by the Kansas Medical Society.

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### A Statement by the Kansas Medical Society\*

Within the last 25 years the science of medicine has advanced more dramatically than ever before. Illnesses that were frequently fatal a generation ago are now being cured, surgical patients are recovering more rapidly, communicable diseases are being controlled and the expected life span of the average American has increased beyond anything dreamed possible at the time of World War I.

The advent of sulfanilamide scarcely ten years ago was considered at the time to be the ultimate in medical achievement. And yet further advancements have arrived such as penicillin and a host of even newer drugs still in the experimental stage. All this is but the beginning of greater things to come as illustrated by research in atomic energy, in enzymes, in disease prevention, in surgery, and in every specialty within the medical profession.

\*This statement by the president of the Kansas Medical Society, Dr. W. M. Mills, is presented in place of the President's Page, usually printed in this section of the Journal.

In war the United States Army had the lowest death rate of any army on earth, much lower than the record of our enemy nations. According to an announcement by Major General Norman T. Kirk, Surgeon General of the United States Army, in World War I statistics concerning soldiers who reached receiving hospitals alive show that the death rate was 14 per cent. In World War II the death rate on a similar basis was reduced to approximately three per cent.

This was accomplished by a free America, a democracy, and represents a record that has never been equalled by socialism, totalitarianism, or a communistic state. It is free enterprise in action which pays dividends in war as in peace by saving lives and reducing illness.

The proponents of federal control concede the point that medical science has advanced. Then they distort facts to prove that medical care is inadequately distributed, and that the cost is prohibitive for all but the well-to-do. The basis of their philosophy is summed up under the statement that federal control would solve these problems.

We also are concerned about exactly the same problems. We too are vitally interested in the distribution of medical care and in its cost. We concede that improvements could be made along these lines, but know that conditions are not as desperate as they say and completely disagree that federal control is the only possible way out. Federal control is not only less satisfactory than other solutions that have been developed, but more expensive. Federal control will react to give the people in this nation poorer medical care.

A local view of this problem will reveal that there are communities in Kansas that do not have a resident physician. On this basis some say that medical distribution in Kansas is faulty. It will also be shown that in certain areas of western Kansas a distance of 40 to 50 miles separates physicians, and immediately the conclusion will be drawn that residents in those areas would suffer in case of an emergency because medical attention is not more nearly at hand. The true problem regarding the distribution of medical care is not this simple, however, and must be viewed from several angles before a proper appreciation of the subject may be obtained.

The first consideration should be the size of these communities and their locations. At the present time, there is no community in Kansas with a population of 2,000 without a doctor. We believe that there is only one community in the state at this time with a population of 1,000 that does not have a doctor. Towns currently asking for physicians are generally under 500 population and frequently have only 100

residents. In all instances, except in the western area of Kansas, there are larger communities a short distance away that do have medical care.

With present transportation facilities, a community without a doctor in residence is not necessarily left without medical care. It can be mathematically proved that a patient in a rural area can ride 15 or 20 miles in a car to a nearby hospital and receive medical care as promptly as could be obtained by the city resident having to drive six miles through heavy traffic. So medical care is no longer determined entirely by miles.

The Kansas Medical Society, nevertheless, is co-operating with the Kansas Hospital Association, the State Board of Health, and local communities in an effort to further improve the distribution of medical care in this state. The 1945 Kansas legislature passed laws permitting virtually any city of the first or second class and any county to build publicly operated hospitals if they desire. Many Kansas communities have already availed themselves of this opportunity and have voted bonds for hospital construction. The Hill-Burton Hospital Construction Act offering financial assistance for hospital construction has become law, thereby further encouraging local communities to improve their hospital facilities. When this program has been completed, it is expected that almost no one in this state will live more than 25 miles from a hospital. Since a community with a well equipped hospital is far more attractive to the physician than the community without such facilities, the Kansas Medical Society is certain that the distribution of medical care in the state of Kansas will materially improve in the next few years.

Compared with fees of a generation ago, the cost of medical care has risen. The increase can be explained on the basis of better care the patient receives today and the greater cost of medical equipment and training. Fifty years ago there were doctors practicing in Kansas who had not attended medical school, who had had no college education, and, in some instances, had not completed high school. At that time medical education was sometimes obtained by apprenticeship in a doctor's office. They studied medical books and went with the practicing physician to visit his patients. After some years they were permitted to take an examination. If they passed, these students received a license to practice medicine in this state. The entire capital investment for equipment frequently consisted of nothing more than a room in their residence, a horse, and a small bag of assorted pills.

The doctor now licensed to practice medicine and surgery in Kansas after a strenuous preparatory course is required to have completed four years in an accredited medical school. He then takes one

year of internship in an approved hospital, during which time he generally is paid less than his actual expenses. More frequently than not, the doctor then proceeds with residency courses for an additional one to five years. During this time he is paid a salary rarely more than \$100 a month. After passing an examination given by the Kansas State Board of Medical Registration and Examination, he is issued a license to practice in this state. Then follows a large expense of equipping his office with modern facilities. For instance, there is x-ray equipment owned by doctors in Kansas costing as much as \$40,000. Surgical instruments of today are more efficient and considerably more expensive than they were a generation ago. Laboratory equipment is costly, and yet some material of this kind is necessary to assist the doctor in making diagnoses.

This equipment purchased by a doctor is used to give the patient better medical care. It serves to add years to the lives of people in Kansas and reduces the number of days they are ill. It also follows that with the greatly increased cost the physician has experienced, his fees will be higher than before. From the patient's point of view, better medical care represents an economic saving to him because he may continue to be productive for a longer period than was possible formerly. Therefore, in relation to value received, the patient of today is actually paying less for medical care. Moreover, in proportion to his earnings, he is also paying less today for medical care than he did during the pioneering era of this state.

The charge has been made that doctors have suddenly become more mercenary than before and that patients formerly treated without cost are today being required to pay. We challenge that statement. For each individual instance illustrating a mercenary attitude, we can present many to support our claim that the situation has not changed at all. There are very few practicing physicians who do not have many thousands of dollars of unpaid care on their books. And yet they continue to serve those who are ill because that is their profession. The doctor considers it his duty and will continue to do that as long as medicine represents an ideal. This ideal has not changed since the days of Hippocrates and will continue until the physician becomes an unwilling employee of a political body.

Nevertheless, the cost of medical care is of serious concern. During the past four years the medical society has studied the possibility of more equitably distributing this cost. On January 1, 1946, Kansas Physicians' Service, a non-profit, voluntary, prepaid medical care plan, authorized by act of the state legislature, came into being. This corporation is underwritten by the doctors of Kansas. It is their plan to

protect the public against the high cost and economic hazards of catastrophic illness. A governmental agency with its costly operation could not provide similar benefits at comparable cost. Participation is voluntary, as it should be. Choice of physician is guaranteed and not merely promised and then made impossible by regulation, as is the case with currently proposed federal legislation.

In spite of previous conceptions to the contrary, the doctor is not unduly fearful of his economic status under a program of federal control. It is not difficult to understand that the practice of medicine will continue to be attractive to the doctor or there will be no medical profession. The doctor is deeply concerned, however, with regard to the patient. Under a federal program, much of the competition that exists today will be eliminated. The doctor will not feel obligated to continue to study because patients will be assigned to him. If he works on a salary, as is possible under this program, there will be less incentive to inconvenience himself in these and in other ways. It will be the patient who will suffer under a program of federal control. In other countries where it has been tried, medicine has degenerated. The cost of medical care has risen. An unbiased study of the program in any country where such a plan has been tried will reveal the truth of the above statement.

The medical profession also wishes to call attention to the fear that other serious consequences would follow the socialization of medicine. If this is accomplished, it will be done over the bitter opposition of at least 90 per cent of those practicing medicine in the United States today. If that is possible in the United States, it also becomes possible to do the same with the legal profession, it can also engulf the newspapers, the churches of this nation, and every industry in existence.

It is only right that where tax funds are involved, regulations should be set up to control the use of those funds. It follows logically that whenever services are provided from tax money, those services will be directed by individuals in charge of the program. In other words, should the federal government pay the cost of medical care, of medical education and of medical research, the federal government would then dictate the conditions under which these services could be provided. If that is possible, it is also possible for the federal government to subsidize the newspapers and to control the material that will be printed. If it is possible for the federal government to direct the physician in the treatment of his patient, it will also be possible for the federal government to direct what might be spoken in our churches. Should such a condition exist, this nation will have lost its freedom of speech and freedom of worship,

which we believe to be two of the principles America recently fought to preserve. The hope of preserving these freedoms was certainly one of the reasons that 60,000 doctors in the United States volunteered their services to the armed forces during the war. Belief in the democracy of America was one of the ideals that led 18,000,000 American men to victory in this conflict.

Signed by W. M. MILLS, M.D., President.

\* \* \*

#### A Statement by the Kansas Hospital Service Association, Inc.

A non-profit health service plan is an organization through which hospitals and doctors, or both, have banded together to make their services available to the community on a prepayment basis. The development of these organizations will be discussed separately.

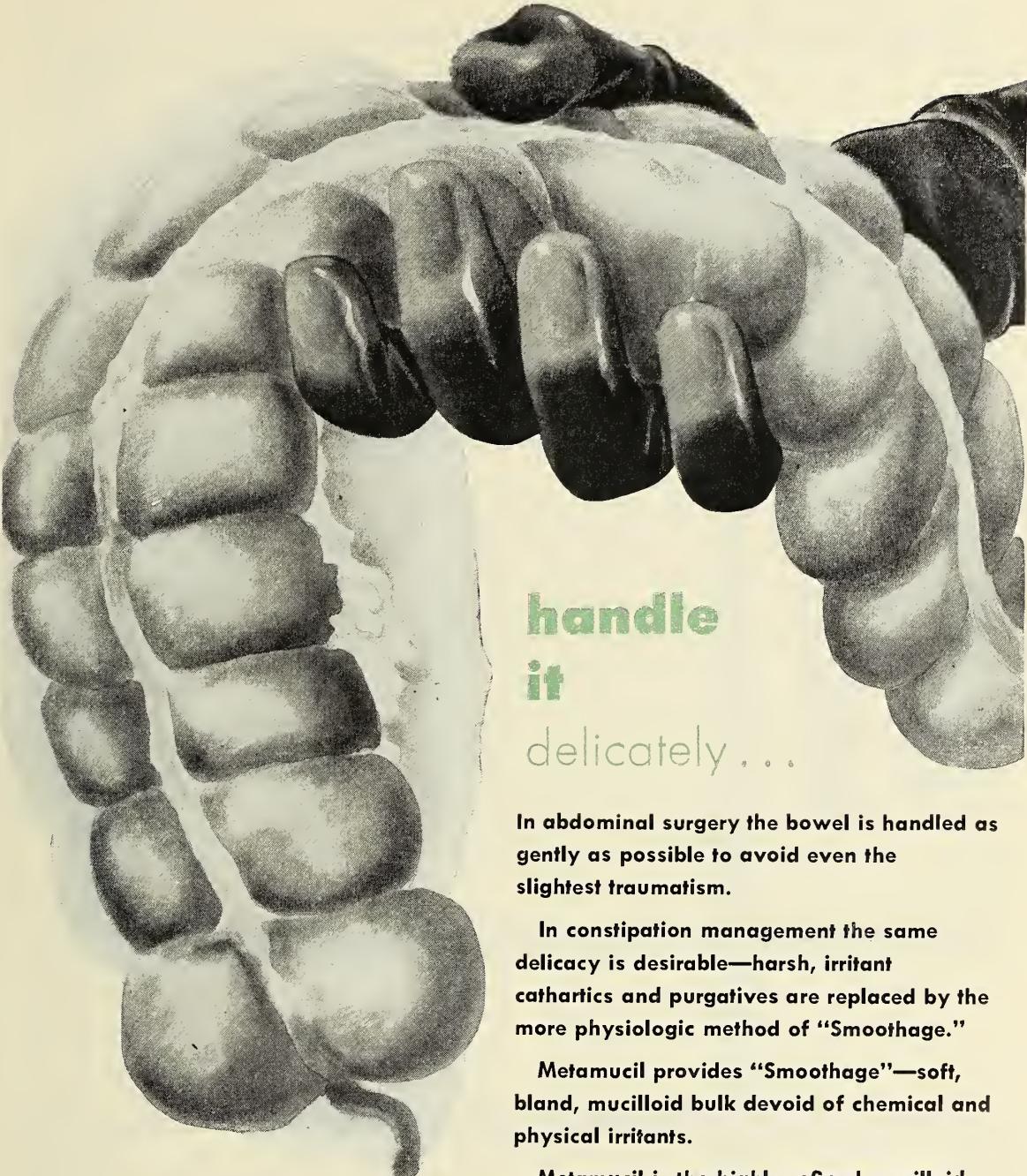
Blue Cross membership is the largest voluntary membership ever to have been recruited in any organization during such a short period of time in the history of the world. In 1937 there were one million members; today there are 25 million.

In 1933 the first group of hospitals formed a non-profit hospital service corporation in Essex county, New Jersey. The purpose was to enable a larger number of people to finance the cost of hospitalization. An early result of the economic depression of the 30's was the failure of people to use hospital facilities because of inability to pay. Despite the fact that the hospitals stood ready to receive all who were in need of care, an individual's self respect too frequently prevented his accepting needed care as a charity patient.

The decision of this group of hospitals that the public needed an easier way to pay for necessary services was eagerly accepted by the community. Immediately thousands of residents of Essex county, New Jersey, began to deposit small sums periodically into the common fund administered by the Hospital Service Corporation. One out of each 10 subscribers was found to need hospitalization annually. His bill was paid, in effect, by the contributions of the other nine.

The ideas of group hospital service spread slowly to other sections of the country until 1937. In that year the trustees of the American Hospital Association sensed the long-term proportions of the movement and devised an approval program. Under this approval program, hospital service plans conforming to the standards laid down by the American Hospital Association were recognized as Blue Cross plans and were privileged to use the seal of the American Hospital Association superimposed on a blue cross as their official emblem.

This official recognition by the American Hos-



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it

delicately . . .

In abdominal surgery the bowel is handled as gently as possible to avoid even the slightest traumatism.

In constipation management the same delicacy is desirable—harsh, irritant cathartics and purgatives are replaced by the more physiologic method of "Smoothage."

Metamucil provides "Smoothage"—soft, bland, mucilloid bulk devoid of chemical and physical irritants.

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RESEARCH IN THE SERVICE OF MEDICINE

pital Association of the soundness of the principle of prepaid hospitalization caused hospital service plans to mushroom. Now the only areas in the nation where the hospitals have not formed a Blue Cross plan are the states of Arkansas, Wyoming, and Mississippi. Establishment of Blue Cross plans in those states is under way. In addition to 81 Blue Cross plans in the United States, there are five serving the provinces of Canada and one in Puerto Rico.

It was only four years ago that critics of Blue Cross said, "The first ten million are the easiest; from now on it will be difficult." It has proved to be the other way around. The rate of growth has increased each year. Last year saw the addition of nearly four million members. After four years of operation, Kansas has 210,000 members. Half of those members were enrolled last year.

The critics of Blue Cross are friendly, well-meaning persons who say Blue Cross is doing a good job as far as it goes but that it can never expect to protect the mass of people. They have contended that the relative ease with which employee-groups have been enrolled will not continue in the enrollment of farmers, self-employed, and the retired. They base this assumption on the knowledge that Blue Cross enrollment must stick to the group principle, in light of which it would be unsafe to allow individuals to join at will. This is true, but the critics have underestimated the ability of American people to find "ways and means" of getting what they want.

In Kansas, for example, the salaried staff of Blue Cross has devoted much of its energies to the development of methods by which groups other than employee-groups may be enrolled. The result is that now the greater part of our new enrollment comes from community groups. These community groups are formed by the people themselves. A continuous educational program has made known the advantages of Blue Cross to community leaders in all sections of the state. On the initiative of the leaders of a community, a field representative of Blue Cross is invited to explain the details of the plan to volunteer workers. These workers accept the responsibility for spreading the news to their neighbors. This method of enrollment results in securing the majority of the population as members.

Persons who work where there are five or more employees join through a group formed at their place of employment. Other persons in the community such as farmers, the self-employed, and the retired join through the community group. Thus Kansas answers its critics by making Blue Cross available to all.

Another early criticism of Blue Cross was that it would be of little interest to the residents of communities not having hospitals. One of the first Kan-

sas Blue Cross groups was made up of the residents of Greeley county. Under the sponsorship of the Greeley County Farm Bureau, a discussion of the Blue Cross was held at the high school in Tribune. Although the county had neither a hospital nor a doctor, not even a nurse, the majority of the residents enrolled. With the nearest hospital 33 miles away, have the Greeley countians found the Blue Cross a good investment? For every dollar paid the Blue Cross in subscription charges, Blue Cross has paid \$1.10 for the care of members in that group. There are many other Kansas counties without hospitals similarly enrolled in Blue Cross whose residents similarly have made adequate use of their memberships. This would indicate that when the cost of hospital care has been removed, distance to the hospital becomes a minor factor.

The most important factor in Blue Cross success is the non-profit character of the movement. The trustees of Blue Cross plans receive no direct or indirect financial advantage for their services. In Kansas one-third of the trustees are hospital administrators or trustees, one third are practicing physicians, and one-third are representatives of the public. This composition of the board is in accordance with a requirement of the special legislation which enabled the incorporation of Blue Cross (Section 40-1802 of the General Statutes, 1941 Supplement—each Blue Cross plan is a corporation under the laws of the state in which it operates). The fact of no direct or indirect financial gain caused Blue Cross trustees to be sensitive to the wishes of the subscribing public. Thus changes in the plan are made from time to time in the interest of the public welfare.

The non-profit character of Blue Cross also is a basis for tax exemption. A tax on operation of Blue Cross would merely raise the cost of hospital care for that portion of the public provident enough to use the prepayment system for placing hospital care in the family budget along with other necessities. In fulfillment of its non-profit character, Blue Cross spends 84 per cent of its income in payment of immediate hospitalization of its members. They set aside four per cent of income into a reserve against epidemics and other possible catastrophes. Twelve per cent is used to cover the expenses of public education, the enrollment of members, the ever-changing records of members, the handling of hospital cases, and all other expenses of operation. In consideration of the rapid growth in so short a time, the proportion of income used for operation is remarkably low. As experience with administrative problems is gained, there should be a continuing reduction in operating costs. For example, one of the older plans operating in a small area, Rhode Island, has already reduced this item to seven per cent of its income.

*"Benzedrine Inhaler appears to eliminate the pain and discomfort which children associate with 'nose drops'... It can be administered with ease even to infants."*

Scarano, J. A., and Coppolino, J. F.:Arch. Pediat. 54:97

### Widespread pediatric acceptance

Children accept treatment with Benzedrine Inhaler, N. N. R., willingly, often with eagerness, and show none of the hostility which so often complicates treatment with drops, tampons, or sprays. The Inhaler, furthermore, produces a shrinkage of the nasal mucosa equal to, or greater than, that produced by ephedrine.

Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 250 mg.; menthol, 12.5 mg.; and aromatics.



### Benzedrine Inhaler *a better means of nasal medication*

Smith, Kline & French Laboratories, Philadelphia, Pa.



Administrative practices of Kansas Blue Cross are reviewed from time to time by subscribers' councils. These local councils are made up of representatives from local subscribing groups. All major changes in policy are cleared through these subscribers' representatives and many of the changes have been suggested by them.

Thus Blue Cross is truly a community service "operated by and for the people." The \$4,000,000,000 of capital investment in American hospitals has been obtained primarily through funds donated by the general public either as philanthropy or taxation. The hospitals of America belong to the people and hospital service is generally recognized as a community responsibility.

Signed by JOHN R. STONE, President.

\* \* \*

#### A Statement by Kansas Physicians' Service

There are many whose economic status causes serious illness to be a financial calamity, possibly even precluding proper or ample treatment. If socialization of medicine means change in methods of distributing medical care to make it more easily and adequately available to these people, then the practice of medicine in America is already well along the road to socialization.

For that is the essence of the purpose behind the plans organized and sponsored by medical societies as exemplified in Kansas Physicians' Service. Kansas Physicians' Service was conceived and developed to make it possible to obtain the best and most adequate medical care whenever needed, without sacrifice of accumulated savings or crippling mortgage of future income. An essential incidental factor is function through a non-profit corporation created to administer the economic phases of medical services on a completely non-profit basis, all charges paid by subscribers being returned in the form of services, excepting only such amounts as are expended for actual administrative costs. This is guaranteed by state control under a specific enabling act of the legislature placing the service under jurisdiction of the office of the state insurance commissioner, setting forth that the work of the administrative body, the board of directors, shall be performed without salary or compensation, and that the membership of the board shall include representatives of the general public appointed by the governor, as well as representatives of the medical profession.

Efficient operation and minimal administrative costs result from utilization of the competent staff already in existence in the Blue Cross organization, the successful plan which has presented hospital benefits in a non-profit prepayment plan with outstanding success for many years. A single staff readily administers promotion, claim investigation and claim

settlement without duplication of staffs or equipment, and with great facility for, broadly speaking, medical services and hospital services are, essentially, merely two component parts of complete health service.

A fundamental principle traditional to establishment of fees for medical services is that the patient shall not be charged more than he can reasonably afford to pay. Those in lower income levels have always paid fees lower than those paid by the more affluent. Following this principle, lower income groups under Kansas Physicians' Service are guaranteed by participating physicians to receive all the services concerned, completely, and regardless of fees involved. In other words, not so many dollars worth of service, but the service itself, the medical care, the operation, the reduction and care of the fracture, the delivery at childbirth, and so forth, instead of a tabulated sum of money to apply against the cost of service furnished. Annual income of \$1,800, or total family income of \$2,400, is the measure of the upper margin of this income classification.

The fees paid to the participating physician, and which he has agreed to accept as payment in full for his services to those in the lower income, or "service" group, are comparable to the relatively reasonable charges usually made to this class of patients. The monthly subscription charges paid by the subscriber are based actuarially on the amounts which will cumulatively meet the demands for payment of such fees.

The monthly subscription charge amounts to 90 cents for the individual, \$2.25 for the family group, regardless of the number of dependents. The all-inclusive family rate carries sociological significance in the easing of expense where easing is most needed, in the large family. Interestingly, this does not work a hardship on the small family group, because the simplified rate structure results in surprising administrative economies which make possible a lowering of the entire rate schedule.

Obviously the low subscription charges will not compensate for the normal fees paid for services to those in the higher income levels. But these individuals recognize the protective value of the medical service plan and demand inclusion. They, therefore, are included as so-called "indemnity" patients and are credited with the fees allowed on the schedule of payments to the participating physician, and the patient himself reimburses the physician for any difference between this schedule and the fee he would usually pay. In actual practice in Kansas, the fee allowed frequently equals that usually paid; rarely is the differential ever a considerable amount.

To serve the people to the greatest extent a low rate structure is considered essential. As this is most

# FACTS

**ABOUT THE  
PREPARATION  
OF**



## *Campbell's* STRAINED BABY SOUPS

**Q. How are meats prepared  
for the soups?**

A. The full protein and other nutritive values in meat are available only when the meat solids as well as the juices of meat are used. Campbell's method of comminuting the meat—superior to the "scraping" common in home use—assures that all the edible solids as well as all the juices are included. Four of the Campbell's Strained Baby Soups have a meat base: Chicken, Liver, Lamb and Beef.

**Q. How are vegetables  
prepared for the soups?**

A. Both the flavor and the nutritive values of vegetables naturally depend in great part upon the way they are handled and cooked. Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins, as well as the wholesome natural flavors.

**Q. How early may  
these soups be started?**

A. That depends entirely upon the individual baby and the physician's judgment. However, these soups are intended for use as early as any strained baby food. The soups are not seasoned (except for light salting) and are of smooth texture and uniform consistency. A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

**5  
KINDS:**

CHICKEN  
BEEF  
LAMB  
LIVER  
VEGETABLE  
*All in Glass  
Jars*



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . and in good flavor. Every resource of Campbell's Kitchens is devoted to that aim.

**LOOK FOR THE RED-AND-WHITE LABEL**

effectively accomplished by the spreading of risk in group enrollments, this method of taking subscribers is adhered to. Some disadvantages ensue but they are greatly overbalanced by the advantages. Experimental enrollments in geographical areas are in process of study and may furnish the solution of most of the shortcomings of group enrollment.

Elimination of coverage for minor disabilities makes an immeasurably lower subscription charge possible. This principle is followed. The various charges for simple colds and various other minor ailments are individually small, but cumulatively, may drain the funds needed for major illnesses. These less important conditions are not a troublesome burden; but, human nature being what it is, they may become an invitation to malingering. It has been shown that including them in any plan raises the necessary subscription charges to a prohibitive point. Repeated public opinion polls have clearly demonstrated that the American public is primarily interested in plans to ease the economic strain of the serious, major illnesses.

Admittedly, many physicians were long distrustful of all plans of the type now in effect. Conservative in viewpoint, individualistic by nature of his profession, the physician awaits scientific justification of changes in his modus operandi, actual "case histories" with successful action before he is convinced. It is only in recent years that the first experimental plans have had convincing actuarial data to present. Now there are only six states without a medical society sponsored plan in operation or in preparation. First convinced of his obligation to help improve the economic relationship of the patient, he later learned there were advantages for him, too: in the freedom from collection problems, the knowledge that he could apply his professional skill to the best interests of the patient disregarding any fear that the financial load to the patient would be difficult or unbearable, the knowledge that he could concentrate on the scientific problem of achieving cure without thought to the involved financial aspects. He has whole-heartedly supported the principle and is now giving it his active and complete cooperation.

Kansas Physicians' Service is the embodiment of the physician's desire to render his patient the finest in scientific medical care, coupled with the most effective proven mechanisms for facilitating the broad unrestricted distribution of such care, unfettered by the stifling regulation and regimentation such as would inevitably accompany any system of politics—bureaucratic control of medical practice with all its evils of inefficiency, red tape, increased costs to the public resulting from involved procedures, notoriously expensive administrative costs, not to mention the divergence of funds which occurs when poli-

ticians find it impossible to resist the temptation to make ulterior use of the enormous collections of funds as would result from the levying of taxes for a national plan of government operated medical service.

Signed by BARRETT A. NELSON, M.D., *President.*

### A.M.A. House of Delegates to Meet

On December 9, 10 and 11 the House of Delegates of the American Medical Association will be called into session for the second time within a year. Public announcements are to the effect that the mass of material currently reaching the American Medical Association makes it necessary that more than one meeting of the House of Delegates be held each year. More than one member, however, is of the opinion that beneath the apparent calm considerable turmoil exists and that the December session may be of special interest.

Not the least in importance among items of business will be a discussion of the Rich report. This firm has completed a survey of the American Medical Association, its mode of operation and its public relations program. In San Francisco last summer the report was alluded to but could not be made public or even read to the House of Delegates, according to the Board of Trustees, because of the confidential material it contained. Since portions of the report have been reasonably well publicized through the Saturday Evening Post, it now appears that there should no longer be a valid reason for the Board of Trustees to keep this information from the House of Delegates.

The remainder of the session will be occupied with the usual routine of business and resolutions. If there are resolutions from Kansas to be submitted to this session of the House of Delegates, they must be sent in immediately. Resolutions should be prepared in triplicate and may be mailed to either J. F. Hassig, M.D., or F. L. Loveland, M.D., delegates from Kansas. From there they must be sent to George F. Lull, M.D., secretary of the American Medical Association, in time to be published before the meeting.

### Refresher Courses at K. U.

The University of Kansas School of Medicine has announced a series of six refresher courses to be presented by members of the faculty and guest speakers who are specialists in each field. World War II veterans may enroll without payment of fee. The following courses are listed in the schedule:

January 13-17—Physical Medicine.

February 24-28—Pediatrics and Public Health.

March 17-21—Internal Medicine and Dermatology.

March 31-April 4—EENT (Primarily for men in general practice.)

April 21-25—Obstetrics and Gynecology.

May 12-16—Surgery.

June 9-13—Radiology and Cancer.

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A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

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## Veterans Administration Agreement

The quality of physical examinations by fee designated examiners is being criticized. This is not directed toward the doctors of Kansas but has been made as a general observation for the nation as a whole. Officials of the Veterans Administration state that examinations are excellent from a medical point of view but that too many are inadequate for rating purposes.

Physical examinations for the Veterans Administration are generally for the purpose of determining disabilities. The decision rests with the rating board, made up largely of lay persons. Therefore, disabilities must be described in detail so there can be no doubt regarding interpretation. It is not enough that a diagnosis be named. It must be qualified in descriptive terms and evaluated in such a way that this board can determine the actual percentage of disability. It is not enough to state that the veteran has a gastric ulcer. The condition must be so described that the board can determine the percentage of disability suffered by that individual patient.

Occasionally the medical examiner attempts to evaluate the patient's disability in percentages. This cannot be accepted since it is the responsibility of the rating board rather than the examining physician. When an examiner makes a diagnosis of arthritis with a 60 per cent disability, the examination must be returned. The physician shall describe the arthritis, the joints involved, and limitations of motion, if any. The rating board will determine the percentage of disability based on the findings of the examiner.

The Veterans Administration does not question the examiner's medical judgment. To have them say that the examination is unfit for rating purposes indicates that it is of no value to them. The Kansas Medical Society has offered this service to the Veterans Administration and sincerely desires to perform the highest quality work. It is once again requested, therefore, that each examiner use special care to describe the patient's condition in such detail that the examination will not be returned.

A second major factor in this program is speed. The Kansas Medical Society is offering assistance so that thousands of pending claims may be acted on more quickly than could be handled by the Veterans Administration alone. It is especially desired that examinations be completed and returned to the Medical Service Center in Topeka as early as possible, but never later than 10 days unless unusual circumstances exist, and then the service center should be informed. It would also benefit the rating board greatly if, wherever possible, the examination form be completed by typewriter. Ink is acceptable if easily legible, but a typewritten examination is preferred.

This is medical-legal work. Serious disturbances will frequently result when the patient is rated at less than the disability to which he is entitled by law. When this occurs, it is generally because the examiner did not give the complete picture. Under those circumstances, the services offered by the medical society are of no value to the Veterans Administration.

Again, in an effort to improve the quality of medical service in Kansas to a point where criticism on this score cannot be applied to this state, another page is reprinted from the Manual for Medical Examiners. This, together with information previously published on malaria, heart and muscles, should be filed for future reference.

### Diabetes

Blood chemistry studies will be made and the claimant's sugar tolerance established. In reports on hospitalized patients, a statement of the type of diet or of the fact of abstention from food intake for any specified period prior to the taking of the blood specimen for estimation of sugar content, will be informative. The specifications in the Schedule for Rating Disabilities give these pictures of relative disability.

(1) Fair tolerance for carbohydrates after treatment, normal blood sugar, urine sugar free, on restricted diet without insulin, no loss of body weight or vigor.

(2) Low carbohydrate tolerance, increased blood sugar, urine sugar free on restricted diet; retention of body weight and vigor, without complications.

(3) Low carbohydrate tolerance, some hyperglycemia or glycosuria on restricted diet, necessitating insulin at intervals, only fair retention of body weight and vigor.

(4) Same as (3) with complications, e. g., ulceration, pruritus ani, repeated furunculosis.

(5) Carbohydrate tolerance extremely low, marked hyperglycemia requiring large doses of insulin, with or without glycosuria, on rigid diet, body weight and vigor not maintained.

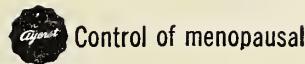
(6) Constant hyperglycemia and glycosuria, acetoneuria and diacetic acid; progressive loss of weight and strength, after sufficient hospital observation shows insulin therapy without effect.

### Nephritis

Robert F. Loeb, discussing the classification of nephritis (*Cecil's Textbook of Medicine*, fourth edition) and quoting Addis' observation that "Every student of Bright's disease constructs his own classification to meet his own individual interests and needs," suggests that "With the present limitations of our knowledge, the chief aim in developing a classification is to find terms which may, for the time being, serve as labels characterizing for the pathologist and clinician the general aspects of Bright's disease in its various forms."

Most classifications of nephritis are anatomical, but the objection thereto is the incongruity between the autopsy findings and the clinical evidences that had been presented in the patients. The classification of Henry A. Christian, and his collaborators (see *Clinical Bulletin No. 12, Nephritis*, Veterans' Administration), which is descriptive of kidney diseases as clinical rather than pathological entities, has met with much favor because of its simplicity and rationality. Edema is the clinical differentiation between two of the three groups in Christian's classification of chronic nephritis. Group (a) is chronic nephritis "with edema." Group (b), "without edema," is characterized instead by hypertension. The third group (c) of chronic nephritis in Christian's classification, viz, "vascular hypertension progressing into nephritis," differs little from (b), "chronic nephritis without edema." The approach of Christian and O'Hare to a satisfactory classification of the nephritides is, in short, the conclusion that it is more serviceable to use a simple grouping descriptive of easily observed features of cases. Edema was selected as a simple criterion. But, since this classification comprehends a clinical basis of division, it can be applied only in the description of symptoms, physical findings, diagnosis and treatment. It cannot be applied as satisfactorily to considerations of etiology and pathology.

Charles P. Emerson (*Textbook of Medicine*, 1936) comments that "Pathologists, basing their classifications on microscopic anatomy, at first described many different



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types of nephritis; but since proof has been given that acute glomerulonephritis, subacute parenchymatous nephritis (the large white kidney), nephrosis, and chronic interstitial nephritis (the small white kidney) are stages of one and the same disease, today they recognize only glomerulonephritis, nephrosclerosis, and certain other rare forms." Emerson further states that while "Clinicians formerly attempted to recognize at the bedside the 15 or more forms of nephritis described by pathologists," they now, "following Christian (1931) would classify all cases as follows: Acute, subacute, hemorrhagic, chronic with renal edema, chronic without renal edema, essential hypertension progressing into chronic Bright's disease, and renal arteriosclerosis progressing into chronic Bright's disease."

Important as corroborative of clinical manifestations (including careful blood pressure determinations) are laboratory examinations of the urine and tests of renal function, e. g., phthalein excretion, blood nonprotein nitrogen, etc.

### Refresher Course in Pathology

A series of refresher studies in pathology will be offered in a twelve-weeks term beginning November 21 under the auspices of the University of Kansas School of Medicine. The following outline for the course lists the subjects to be discussed during the Thursday sessions:

Nov. 21.—BREAST: Discussion will include inflammatory lesions and both benign and malignant tumors.

Dec. 5—UTERUS: Benign and malignant lesions of the uterine body as well as those of the cervix, with special reference to interpretation of biopsies and curettages.

Dec. 12—FEMALE GENITALIA: Lesions of the tubes, ovaries and external genitalia.

Dec. 19—SKIN: Cutaneous diseases, including inflammatory and degenerative, as well as various types of neoplasms.

Jan. 2—GENITO-URINARY TRACT: Lesions of the testicles, prostate, bladder and ureters.

Jan. 9—KIDNEY: Various types of nephritis as well as renal hypertension, tuberculosis, and tumors.

Jan. 16—GALLBLADDER AND LIVER: Benign and malignant growths of the gallbladder, pathogenesis of gallstones, interpretation of biopsies of the liver associated with a brief discussion on the pathology of the liver.

Jan. 23—LYMPH NODES: Biopsies removed from lymph nodes and their differentiations, and differential diagnoses of various lesions and tumors of lymphatic tissue.

Jan. 30—THYROID: Various goiters, interpretation of biopsies, and an attempt to correlate the pathological changes with the clinical findings. Considerable time will be devoted to the various types of tumors arising in the thyroid.

Feb. 6—GASTRO-INTESTINAL TRACT. The main lesions, both inflammatory and neoplastic, of the stomach, esophagus, small and large intestines, and rectum.

Feb. 13—RESPIRATORY TRACT: Inflammatory and neoplastic lesions and interpretation of biopsies of the bronchi and larynx.

Feb. 20—HEMATOPOIETIC SYSTEM AND BONE: The tissue changes occurring in the bone marrow and lymph nodes, leukemia, and various other blood diseases, as well as a brief discussion of splenomegaly and its relation to the organs of the reticulo-lymphatic system; bone tumors, radiology.

### Urge Aid for Cancer Patients

Dr. George T. Pack, chairman of the Medical and Scientific Council of the National Cancer Foundation, stressed

the need for improved facilities for caring for cancer patients when he spoke before the first official meeting of the Board of Directors of the newly formed foundation.

"Almost every home in the country has been afflicted with the disease," he said. "All citizens should take action to stimulate local and state interest, as well as federal means to provide proper hospitalization for deserving cancer patients.

"General and special hospitals in the United States are already taxed beyond capacity. It will be several years before they can accommodate the number of people who need hospital care even of short duration. These hospital rooms and beds, so constantly occupied, cannot readily be turned over to patients with chronic disabling diseases such as cancer. People with advanced cancer may require continuous nursing and medical attention for several months or even several years. Even the most humane and sympathetic hospital director could not conscientiously allocate a considerable number of his precious beds for the care of a few people for so long a time."

Emphasizing that the average home is not prepared to accommodate itself to months of invalidism involved when a member of a family is stricken with cancer, beyond hope of control, Dr. Pack said, "the tragedy in each instance in addition to realizing and accepting the impending loss, is the unexpected hardships entailed in the daily nursing by some relative who is physically, emotionally and scientifically unfit for this trying task."

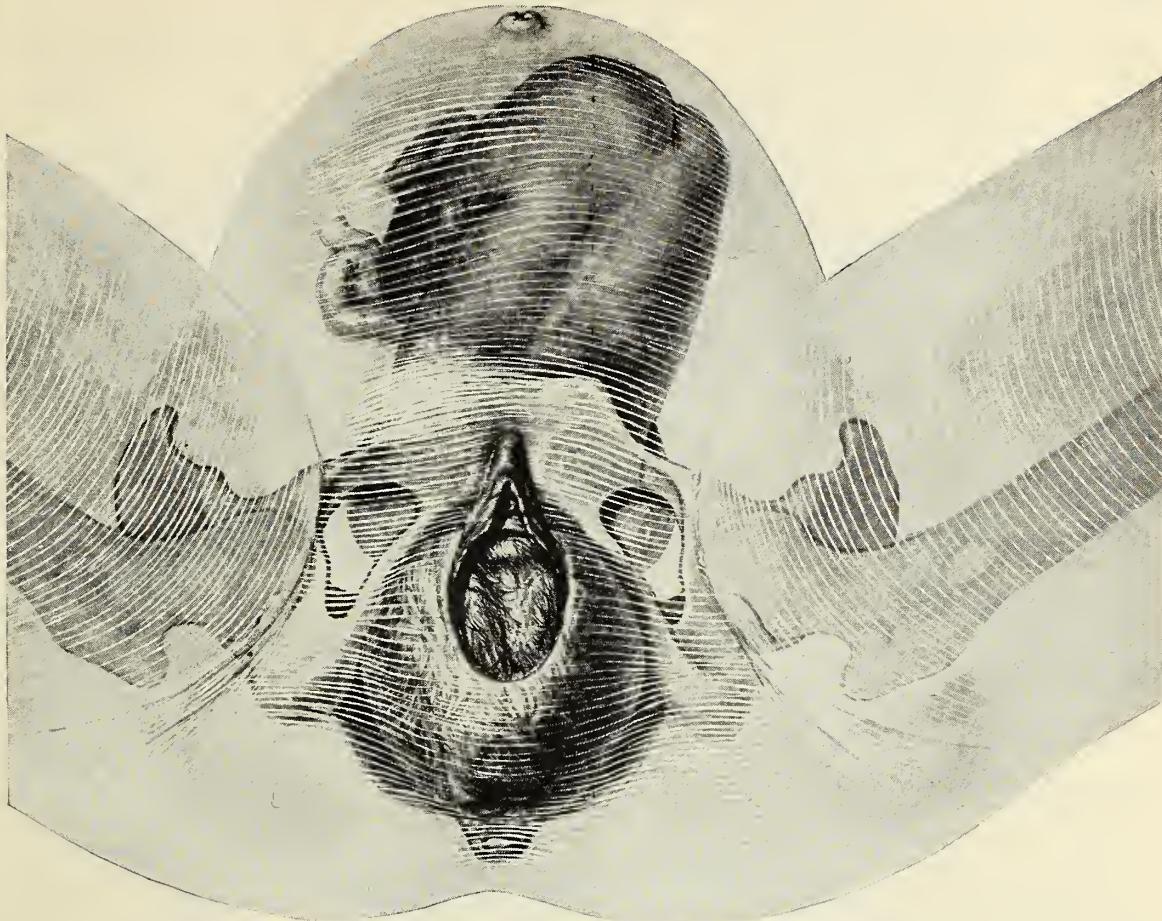
### Proposed Amendment to By-laws

The Council of the Kansas Medical Society, in session at Topeka on October 6, 1946, unanimously approved an amendment to the By-laws of the Constitution designed to expedite handling of finances for the Journal of the Kansas Medical Society. The request for this amendment reached the Council from the Editorial Board of the Journal, and the Council recommends the introduction of this amendment at the first meeting of the 1947 House of Delegates.

#### By-laws, Chapter X—Editorial Board—Section 7.

This section now reads, "Funds of the JOURNAL and other publications shall be accounted in separate ledgers, and shall preferably be maintained in separate banking institutions. Bills for expenditures authorized by the Editorial Board and approved by the chairman of the Board shall be paid by vouchers signed by the treasurer and countersigned by the president and secretary. Surplus funds may be accrued at the end of the fiscal year to reserve accounts within limits established by the House of Delegates or the Council."

This section shall be amended to read, "Funds of the JOURNAL and other publications shall be accounted in separate ledgers, and shall preferably be maintained in separate banking institutions. Bills for expenditures authorized by the Editorial Board and approved by the chairman of the Board shall be paid by vouchers signed by the Chairman of the Board and countersigned by either the managing editor or the business manager of the Journal of the Kansas Medical Society. The Chairman of the Board, the managing editor and the business manager shall be individually bonded for sums not less than \$5,000. Certification of all vouchers written shall be mailed not less frequently than once each month to the president, the secretary and the treasurer of the Kansas Medical Society. Surplus funds may be accrued at the end of the fiscal year to reserve accounts within limits established by the House of Delegates or the Council."



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## MEMBERS

Dr. F. W. Foncannon, who has been associated in practice with his father, Dr. Frank Foncannon, in Emporia since his release from the service last January, has enrolled in the postgraduate school at the University of Pennsylvania for a year's course in surgery.

\* \* \*

Dr Louis R. Haas, Pittsburg, presented a paper, "The Control of Allergy in Nose and Throat Practice," at the Detroit meeting of the International College of Surgeons in October. Dr. Haas was recently elected a fellow of the College.

\* \* \*

Commander Vaughan C. Price, who has been stationed at the Naval Hospital at Corpus Christi, Texas, has advised the Journal that he is returning to McPherson, where he practiced before entering the service.

\* \* \*

Dr. Howard Snyder, Winfield, went to Rio de Janeiro early in September to attend the First Inter-American Medical Congress. All American countries except one were represented on the list of speakers and delegates. Dr. Snyder addressed the congress on "Organization and Function of the Service of Blood Transfusion During the War."

\* \* \*

Dr. Claude C. Tucker, Wichita, was elected vice president of the American Proctological Society at a meeting held at San Francisco before the A.M.A. convention in July.

\* \* \*

Dr. Roy K. Smith, a member of the Northwest Kansas Medical Society, has advised the Journal that he is now director of tuberculosis sanatoria for Korea under the military government at Mason, Korea.

\* \* \*

Dr. R. E. White, Dr. T. A. Hood and Dr. J. P. Fairchild, Garnett, have announced that they are now engaged in group practice there.

\* \* \*

Dr. Charles E. Stevenson, who was released from the service in July, has announced the opening of an office in Neodesha. During the war he served as battalion surgeon of a marine unit in Tientsin, China.

\* \* \*

Dr. John C. Caldwell, who has been practicing in Wellington more than 47 years, announced his retirement on November 1.

\* \* \*

Dr. V. E. Chesky, who was associated in practice with the late Dr. Arthur E. Hertzler, Halstead, for 30 years, has been elected medical head and chief of staff at the Hertzler clinic and Halstead hospital. The clinic, under the terms of Dr. Hertzler's will, was bequeathed to Dr. Irene Koeneke, Dr. Chesky, Dr. George Westfall, Dr. L. E. Peckenschneider and Dr. Thomas L. Foster, all members of the staff.

\* \* \*

Dr. Donald Bux, Columbus, resigned his position as Cherokee county health director last month to enter private practice in association with Dr. G. B. Athy in Columbus.

\* \* \*

Dr. Norman A. Burkett, Junction City, who was recently released from the Army after having served in the E.T.O., resumed his duties as Geary county health officer last month.

Dr. B. A. Nelson, Manhattan, has been elected a commissioner in Associated Medical Care Plans, Inc., an organization designed to unify prepaid medical care plans throughout the United States.

## COUNTY SOCIETIES

Twenty members of the Labette County Medical Society were present at a meeting held at the health center, Parsons, on September 25. Dr. C. E. Virden, Kansas City, spoke on x-ray and lantern slides of the gastro-intestinal tract.

\* \* \*

Members of the Stafford County Society met October 7 at the Hi-Way Cafe, Macksville, to discuss plans for diphtheria immunization and smallpox vaccination under a program recently arranged by the board of county commissioners.

\* \* \*

The regular meeting of the Crawford County Society was held at the Hotel Besse, Pittsburg, September 26, with 25 members present. Dr. C. Herbert Smith, Pittsburg, spoke on "Rigid Bone Fixation" and illustrated his lecture with motion pictures.

\* \* \*

Members of the Golden Belt Medical Society held their regular meeting on October 3 at the Hotel Jayhawk, Topeka. The following scientific papers were presented: "Some of the Simpler Procedures in Plastic Surgery" by Dr. Lewis Byars, St. Louis; "Modern Concept of Cirrhosis of the Liver and its Therapy" by Dr. Charles Mount, Winter Hospital, Topeka; "The Role of Allergy in Internal Medicine" by Dr. Stanley F. Hampton, St. Louis, and "Cyanosis of the Newborn from Well Water" by Dr. Lucius E. Eckles, Topeka. The scientific program was followed by a dinner and informal evening session.

\* \* \*

The October meeting of the Crawford County Society was held on the 24th at the Hotel Besse, Pittsburg. Dr. Carl S. Newman, in charge of the program, introduced Dr. R. W. Urie, Parsons, who spoke on "Armamentarium Against Cancer" with a discussion by Dr. Charles Miller, Parsons. Dr. C. H. Benage, councilor for that district, reported on district news.

\* \* \*

The Shawnee County Medical Society met October 7 at Topeka. Dr. Edward Massie, of Washington University, St. Louis, spoke on "Correlations between Hypertension and Kidney Disease—A Clinical Test for Sympathectomy." Proposed changes in the Constitution and By-laws of the group were discussed and will be presented for vote at the November meeting.

\* \* \*

Research on animals for the development of live-saving medical knowledge has been endorsed by the Chamber of Commerce of the United States in a statement of policy released recently by Howard Strong, secretary of the Health Advisory Council of the Chamber of Commerce. Results of the vote showed 2424 organizations in favor of the policy and 18 against, voters representing over a million business men.

The statement submitted for the vote is as follows: "In view of the great progress that has been made in preventive and curative medicine and surgery through animal research and the prospect of even greater progress in the future, the National Chamber is unalterably opposed to the prohibition of this scientific procedure. Such a prohibition would seriously hamper all medical progress."



Modern surgical care recognizes that it takes more than gauze and adhesive to "bind the wounds" of the operative case. It has been demonstrated that the prevention and treatment of nutritional deficiencies may be "decisive factors" in recovery following surgery.<sup>1</sup> In the field of oral and parenteral vitamins, Upjohn offers a full range of highly potent, convenient to administer, economical vitamins.

<sup>1</sup> Am. J. Surg. 44:288 (April) 1942.

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**U P J O H N V I T A M I N S**

## BOOK REVIEWS

*Penicillin, Its Practical Application.* Under the General Editorship of Sir Alexander Fleming. Published by the Blakiston Company, Philadelphia. 380 pages, 59 illustrations. Price \$7.00.

This book has been written by a number of English authorities under the general editorship of Professor Fleming. The book is divided into a general and a clinical section. Particularly useful in the general section is the chapter by Professor Fleming on "Bacteriological Control of Penicillin Therapy." The techniques for penicillin assay, for determination of penicillin levels in body fluids and of penicillin sensitivity of organisms, and for determination of penicillinase are clearly presented.

Clinicians in various specialties have contributed chapters to the comprehensive clinical section. Excellent case reports are presented and pitfalls are pointed out. Dosages in general are somewhat lower than in American practice, in part due to the relative scarcity, until recently, of penicillin in England. During the war years, most penicillin was produced by flask culture, because of inability to obtain materials to build tank culture plants.

This excellent presentation can be recommended without reserve. It is well edited and has comprehensive bibliographies and a good index.—Norris L. Brookens, M.D.

\* \* \*

*Courage and Devotion Beyond the Call of Duty.* Second preliminary edition. Published by Mead Johnson and Company, Evansville, Indiana.

This book, following the first preliminary edition published in November, 1944, is a partial record of official citations to medical officers and military groups in the United States Armed Forces during World War II. A full page is devoted to each officer named in a citation, and in most instances the wording of the citation is quoted, along with a resume of the doctor's military experience. Names are listed alphabetically.

At least nine Kansas physicians are listed in this edition of "Courage and Devotion Beyond the Call of Duty," and other names may be added before the complete edition is published. The book will constitute a valuable historical record of the accomplishments of individual physicians in the conflict.

On the inside cover of this edition is the following announcement: "The publisher invites additions and corrections for inclusion in the complete postwar edition of this work. Copies of the complete edition will be available only upon written request."

\* \* \*

*Diseases of the Retina.* By Herman Elwyn, M.D. Published by the Blakiston Company, Philadelphia. 593 pages, 170 illustrations. Price \$10.

This is an up-to-date, compact, concise discussion of the various diseases of the retina. The book is divided into the following parts: (1) Disturbances in Circulation; (2) Vascular Malformations; (3) Degenerative and Hereditary Changes; (4) Inflammatory Diseases; (5) Tremors; (6) Detachment; (7) Developmental Anomalies and (8) Radiation Injuries.

Under each heading, the clinical picture, etiology or pathogenesis, treatment and pathological reports are discussed. This is based on the author's wide experience and, in addition, on excerpts of case reports collected from the literature. The circulatory disturbances are discussed and explained in a very understandable manner, and the section on hereditary and degenerative diseases is quite complete. There is a good bibliography with each part.

Because the retina participates in many systemic disorders, this book will be of interest to others than those specializing in ophthalmology.

The book has a cloth binding; it is printed on a good quality of smooth paper; the printing is large and well-spaced, which makes for easy reading and quick reference.—Byron J. Ashley, M.D.

\* \* \*

*Diabetes, a Concise Presentation.* By Henry A. John, M.A., M.D., F.A.C.P. Published by C. V. Mosby Company, St. Louis 3, Missouri. 300 pages. Price \$3.25.

The author has recorded his observations and conclusions based on an abundant experience in the management of diabetics. He does not approve of the common practice of relying on glycosuria as the sole criterion of sugar metabolism: "Every day we let a patient carry hyperglycemia he has that much less pancreas left."

He has little fear of repeated hypoglycemic attacks except in arteriosclerotic individuals, and advocates maintenance of as low a blood sugar level as possible. All aspects of diabetes are considered and there is a good chapter on diet with food tables, charts and recipes.—Don C. Wakeham, M.D.

## BOOKS RECEIVED

*The Chest, Handbook of Roentgen Diagnosis.* By Leo G. Rigler, M.D. Published by Year Book Publishers, Inc., Chicago. Copyright 1946. 352 pages. Price \$6.50.

\* \* \*

*Hygiene, Fourth Edition.* By F. L. Meredith, M.D. Published by the Blakiston Company, Philadelphia. Copyright 1946. 838 pages. Price \$4.00.

## CLASSIFIED ADVERTISEMENTS

**CRUTCHES** with tips, \$1.89 pair postpaid. Braces made repaired, altered. Prompt service. BOSWORTH BRACE SHOP, 416 N. Water, Wichita, Kansas.

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**FOR SALE**—Fixtures of eye, ear, nose and throat office, instruments and cabinet, ophthalmometer, surgical chair and table, head lamp, etc. Write the Journal C-0-57.

**FOR SALE**—Examining chair and table, small table for supplies, surgical instruments, instrument cabinet, large electric cautery, medicine cabinet, and a few smaller items. Write the Journal C-0-58.

**FOR SALE**—one Beaumont hydraulic lift steel chair table (Sharpe and Smith manufacturers), one McDannold chair, one EENT steel chair, one portable operating table, a few instruments and drug cabinets. Write the Journal C-0-59.

**FOR SALE**—28-bed hospital (22 private rooms and 6-bed ward), built in 1929 at cost of \$40,000, now offered at \$30,000. Equipment includes bed, chair and dresser for each room and enough linen and blankets to run 20 beds. For complete information write the Journal C-0-60.

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The **Page**

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## ANNOUNCEMENTS

- November 17-23—Inter-American Congress of Radiology, Havana, Cuba. Information may be secured through American College of Radiology, 20 North Wacker Drive, Chicago, Illinois.
- November 25-27—Annual Convention, American Academy of Allergy, Hotel Pennsylvania, New York City. No registration fee. Program may be obtained from Dr. Horace S. Baldwin, 136 East 64th Street, New York City.
- December 4-5—Meeting, Kansas State Board of Medical Registration and Examination, Kansas City, Kansas.
- December 7-12—Fifth Annual Meeting, American Academy of Dermatology and Syphilology, Cleveland, Ohio.
- December 16-17—Rocky Mountain Conference on Poliomyelitis under auspices of School of Medicine and Hospitals, University of Colorado, Denver. An open invitation is extended to all members of the Kansas Medical Society.
- February 7—Written Examination, American Board of Obstetrics and Gynecology, Inc. Change in requirements now effective provides that case records must be forwarded to the secretary's office from 30 to 60 days after candidates have received notice of eligibility for admission to examinations. Candidates will be examined in both branches of the specialty of obstetrics-gynecology. For information address Paul Titus, M.D., 1015 Highland Building, Pittsburgh 6, Pennsylvania.
- March 17-20—Sixteenth Spring Clinical Conference, Dallas Southern Clinical Society, Hotel Adolphus, Dallas, Texas.
- April 28-May 2—Annual Session, American College of Physicians, Chicago, Illinois.
- MAY 12-15—ANNUAL MEETING, KANSAS MEDICAL SOCIETY, TOPEKA, KANSAS.

Fifteen per cent of all carcinomas encountered are located in the large intestine. About two-thirds of these occur after the age of 50, but quite a number appear before the age of 30. In younger patients the lesions are characterized by shorter duration of symptoms, a higher index of malignancy, greater frequency of metastases and "inoperability," and a diminished proportion of five-year survivals after treatment.

Accumulating evidence indicates that most cancers of the colon have their origin in polypoid growths. Early diagnosis and prevention of colonic cancer may therefore be facilitated by recognition of polyps before they have had time to undergo malignant degeneration or while the degenerative change is still in an early state of development. All colonic tumors should be treated as malignant growths, because biopsy alone can determine their nature.—Illinois Cancer Bulletin, August 10, 1946.

\* \* \*

Since the casual factor of recurring or persistent sciatic pain was pointed out in 1934 as a common entity, a great deal of study has been devoted to the syndrome of herniating intervertebral disk. The discovery of this syndrome is one of the important advances of the century and provides a solution to a serious problem of relatively high incidence. Thousands of patients have been operated on, and many reports have been made. In the earlier days, caution led to the visualization of the herniating disk by myelography with iodized poppyseed oil and air and to prolonged conservative treatment before operation was resorted to. Time and experience have led to the conclusion that chronicity, unilaterality and typical radiation of sciatic pain to a leg or ankle means herniating intervertebral disk until otherwise proved. The diagnosis has proved to be accurate in 90 to 95 per cent of cases—as high an accuracy as in the

diagnosis of any nonvisualized pathologic entity. The syndrome of herniating intervertebral disk is predominantly that of pain in a nerve root because the protruding portion of the disk compresses a nerve root against the ligamentum flavum adjacent to it. Because 90 to 98 per cent of the pathologic disks are below the fourth or fifth lumbar vertebra, the important and usual features in the history are as follows:

Chronic pain low in the back is referred to the level of the sacrum or lumbosacral joint and is associated with pain in the region of the sciatic notch, radiating down the posterior aspect of the thigh and to the calf or lateral aspect of the leg and often to the ankle, heel, entire foot or either side of the foot. About 25 per cent of the patients deny the presence of pain low in the back and describe only sciatic pain. A small percentage of patients experience sciatic pain on both sides, and in these patients the pain is usually unilateral for some time before becoming bilateral. This is an indication that the herniation has become extensive enough to compress the corresponding roots on each side of the spinal canal. One of the notable features, however, concerning herniating disks is that the herniation and hence the sciatic pain are so commonly unilateral and associated with no pain whatever or at any time in the opposite extremity.—Olan R. Hyndman, M.D., Archives of Surgery, September 1946.

\* \* \*

New horizons of medical and biological research were opened when the Manhattan Engineer District, key organization in the development of the atomic bomb, delivered the first radioactive isotopes to the nation's research institutions.

First peacetime products of the government's huge atomic energy facilities were pea-sized units of Carbon-14, which for the next 10,000 to 25,000 years will emit 37 million beta particles per second, and will be used in research in connection with cancer, diabetes, photosynthesis, carbon deposition in the teeth and bones and in the utilization of fats by the human body.

Barnard Free Skin and Cancer Hospital of St. Louis received the first unit for study of the processes by which cancer is produced. The hospital's application was the first cleared through the necessarily elaborate distribution procedure.

### Exhibits for A.M.A. Centennial Session

Scientific exhibits at the centennial session of the American Medical Association, to be held in Atlantic City, June 9-13, 1947, will include the history of medicine during the past century and the latest developments of medical science.

The Committee on Scientific Exhibits has announced also that application blanks for space are now available and must be filled out and submitted before January 13, 1947. After that date the committee will make its decision and notify applicants. Application blanks may be secured from The Director, Scientific Exhibits, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

In 1500 B. C., the citizens of Thebes were complaining that there were no longer any good old family physicians. Every one was a specialist. "The practice of medicine," writes Herodotus, the Greek historian, "is so divided among them that each physician is a healer of one disease and no more. All the country is full of physicians, some of the eye, some of the teeth, some of what pertains to the belly." —Journal of the Iowa State Medical Society, October, 1946.

**THE JOURNAL**  
*of the*  
**KANSAS MEDICAL SOCIETY**

*Owned and Published by The Kansas Medical Society*

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Volume XLVII

DECEMBER, 1946

Number 12

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**PRINCIPLES OF TREATMENT IN PRE-ECLAMPSIA  
AND ECLAMPSIA\***

J. Robert Willson, M.D.\*\*

Chicago, Illinois

The term "toxemia of pregnancy" is one which includes not only pre-eclampsia and eclampsia but hypertensive disease and nephritis with a superimposed pregnancy. The former two conditions, which constitute about forty to fifty per cent of all toxemias, are peculiar to pregnancy, almost always appear during the latter half of the period of gestation, and are characterized by hypertension, proteinuria, and edema. The importance of the early recognition and institution of treatment is emphasized by the mortality rates which increase from 0.4 per cent for the mild cases to an average of 13 per cent for eclampsia.

Although our knowledge of these conditions has been increased tremendously by the volume of investigation carried out over the years, the etiology is as yet undetermined and pre-eclampsia cannot be prevented; however, its course can be modified by early diagnosis and judicious care thus forestalling its progression to the convulsive state.

Almost all cases present minimal early signs the first of which is an *abnormal gain in weight*. We believe that the optimum total weight gain for normal pregnancy is from fifteen to eighteen pounds and that gains of more than one-half pound weekly during the last half of pregnancy indicate an abnormal retention of water. *In almost all instances a period of abnormal weight gain precedes the appearance of edema.* Although slight ankle edema is not uncommon in normal pregnant patients, pitting edema over the tibiae is an indication that fluid retention is greater than the expected amount.

Elevation in blood pressure above 140/90 or a total increase in systolic pressure of 30 mm. Hg. is indicative of abnormality. The blood pressure is not

necessarily increased to alarming levels in pre-eclampsia or even in eclampsia, the mean systolic pressure in the former group being from 147-169 and in the latter 174. Hence a feeling of complacency concerning any patient with signs suggesting pre-eclampsia even though the blood pressure is only slightly elevated is unwarranted.

The total amount of protein excreted in a 24-hour urine specimen by the normally pregnant patient is less than 0.06 gm. This is increased in pre-eclampsia and the more severe the condition the greater the amount of protein put out by the kidney. The common method of estimating the amount of proteinuria by grading the reaction from + to ++ may at times be misleading; for instance, a given amount of protein in 2000 cc. of urine may be read as + whereas the same amount in 500 cc. may be ++, consequently the quantitative measurement of the total 24-hour excretion is a more accurate indication of the renal function and should be carried out in all patients with toxemia.

**TREATMENT**

The signs and symptoms of pre-eclampsia have been divided into groups which indicate progressive severity of the condition and which may be utilized as an aid in guiding treatment. (Table I)

In the usual patient who has only the signs of toxemia (group A) hospitalization is unnecessary but a carefully outlined regime of therapy and frequent observation is of utmost importance. Treatment is directed toward reversing or at least stabilizing the signs and preventing the occurrence of eclampsia. If careful medical management is begun at an early stage in the disease, increase in severity can in most cases be prevented, at least until induction of labor is feasible.

The effectiveness of the office treatment of the mild pre-eclamptic may be gauged by (1) control

\*Presented at the 87th annual meeting of the Kansas Medical Society, April 24, 1946.

\*\*From the Department of Obstetrics and Gynecology, The University of Chicago Medical School and the Chicago Lying-in Hospital.

of weight (edema), (2) control of blood pressure, (3) maintenance of urine output, (4) stabilization of the 24-hour protein excretion, and (5) prevention of symptoms.

Since fluid accumulation in the tissue spaces is a direct result of abnormal retention of salt, a reversal may be anticipated if the sodium chloride content can be reduced thus freeing the water. This may be accomplished by a diet such as our "Pre-eclamptic diet" which contains less than two gm. Na Cl daily. If the patient adheres strictly to this diet the tissue electrolytes will be utilized by the body and the excess water which was holding them in solution will be excreted, thus both relieving the edema and supplying fluid to the kidney for the formation of urine. Ammonium chloride in dosages of 8 gm. daily may increase the rapidity with which the fluid is released. Mild sedation with phenobarbital (0.06 gm. Tid and at bedtime), mental relaxation, and at least ten hours in bed daily will aid in preventing further elevation of the blood pressure. Blood pressure determinations and weights should be taken at weekly intervals and the measurement of the 24-hour protein excretion should be made at least twice weekly. Success in control on this regime is indicated by a regression or failure of progression of the signs of toxemia. Failure is indicated by:

1. Progressive increase in blood pressure.
2. Progressive gain in weight or an increase in the amount of edema.
3. Increase of proteinuria.
4. Development of symptoms (group B).

Such a failure makes hospitalization and the institution of more active therapy imperative.

Advance in severity of the toxemia is characterized by a progressive diminution in urinary output

with an increase in total protein, further elevation of blood pressure, hemoconcentration as indicated by an increase in cell volume and red cell counts, and in many cases the appearance of symptoms which become progressively more pronounced. Severe pre-eclampsia is characterized by (a) two or more of the following: repeated blood pressures greater than 160/100 mm. Hg., proteinuria more than 0.3 gm. per cent, or marked edema; (b) at least one of the following: repeated systolic blood pressures greater than 185 mm. Hg., proteinuria more than 0.5 gm. per cent, or generalized edema; or (c) one of the signs in (a) accompanied by cerebral, gastrointestinal, visual, or renal symptoms.

The initial hospital treatment of pre-eclampsia concerns itself primarily with the classification of the severity of the condition and the initiation of a regime designed to control the signs and symptoms. With the exception of an evaluation of the duration of pregnancy, the size and position of the fetus and the adequacy of the pelvis, the pregnancy is, at the onset, ignored.

The most important factor in the management of severe pre-eclampsia is the maintenance or promotion of urine output which is diminished as the fluid components of the blood are drawn from the blood vessels into the tissues. This is an essential step in the prevention of eclampsia and in most instances can be achieved by the proper use of hypertonic glucose solutions which reverse the fluid exchange drawing the edema fluid back into the blood stream thus diluting the concentrated blood making available fluid for the kidney to excrete. These solutions likewise aid in diminishing the cerebral symptoms and in preventing convulsions due to their action of dehydrating the brain. Since the purpose of the glucose is to increase osmotic pressure in the vessels and thus draw fluid

TABLE I  
SIGNS AND SYMPTOMS OF TOXEMIA

GROUP A			
Edema (weight)		Hypertension	Proteinuria
GROUP B			
Cerebral	Visual	Gastrointestinal	Renal
Headache	Diplopia	Nausea	Oliguria
Dizziness	Scotomata	Vomiting	Anuria
Tinnitus	Blurred vision	Epigastric pain	Hematuria
Drowsiness	Amaurosis	Hematemesis	Hemoglobinuria
Amnesia		Jaundice	
Change in respiratory rate			
Tachycardia			
Fever			
GROUP C			
Convulsions			
Coma			

from the tissues, the solutions must be administered rapidly (40-60 minutes) in order to produce as high a blood level as is possible. Approximately 200 gm. of glucose produce the best diuretic response; this usually is administered as a 20 per cent solution of which 1000 cc. is given. Great care must be taken to prevent tissue infiltration. The injection may be repeated two or three times daily to maintain an adequate output. The mercurial and xanthine diuretics are of no value in correcting the oliguria because their action is directly on the kidney; unless the hemoconcentration is corrected by reversal of the fluid exchange, no increase in urine can be anticipated. Careful records of fluid intake and urine output are essential as an aid in determining the effect of therapy.

Daily quantitative determination of the total protein excretion likewise is of prognostic significance. A steady increase or a constant excretion of more than 3-5 grams daily is a grave sign indicating a failure of medical treatment to control the disease. Daily protein excretion greater than 5 gm. is associated with a definite increase in intrauterine fetal death.

Bed rest and sedation with phenobarbital will aid in controlling the blood pressure which should be recorded twice daily.

If the response to this regime is favorable, that is, if an adequate urine output (1200-1500 cc.) is maintained, the proteinuria does not increase, the blood pressure is controlled, and symptoms improve, the patient may be carried until the cervix is "ripe" at which time labor should be induced by rupture of membrane and the injection of one minim doses of pitocin at 30-minute intervals if contractions have not begun in twelve hours. Pitocin is used rather than pituitrin because of the absence of the anti-diuretic principle in the former preparation.

The decision as to when the cervix is "ripe" is of utmost importance since rupture of membranes before conditions are favorable usually results in failure of labor to begin. The ripe cervix in the primigravida is effaced, soft and dilatable, whereas in the multipara it is soft and open but not neces-

sarily thinned out since in the latter dilatation and effacement occur simultaneously while in the former effacement is completed before much enlargement of the cervical opening occurs.

Cesarean section should be considered as a method of delivery only if there is a well defined indication for abdominal delivery or in the occasional patient in whom the progression of the toxemia cannot be controlled by medical management and in whom delivery from below is impossible due to an unprepared cervix. In these instances delivery becomes imperative in order to prevent the development of eclampsia.

Should the patient, either through failure on her part to report to her physician or through failure on the part of the physician to interpret correctly the signs of advancing pre-eclampsia develop convulsions, the prognosis at once becomes grave. Since the mortality rate rises both as the number of convulsions and the duration of the disease increase (Tables II-III), prompt institution of therapy is a necessity.

The presence of a pregnancy is the important factor in the development of eclampsia, hence removal of the products of conception must constitute a major part of treatment. The decision, however, as to when and how the pregnancy is terminated may mean the difference between life and death to the patient. Immediate surgical treatment (accouchement force, vaginal hysterotomy, or cesarean section) is associated with a high maternal mortality; on the other hand, while strict medical treatment without concern for the pregnancy will reduce this mortality, it will not improve all cases. Hence the obstetrical treatment, a combination of medical control of the toxemia and interruption of the pregnancy at a suitable time, seems the most logical approach to the problem.

Any case of eclampsia is serious. However, gradations in severity of the condition are observed and prognosis and treatment may be governed by a division of cases into mild and severe types. Our

TABLE II

NUMBER OF CONVULSIONS AND MORTALITY

Number of Convulsions	Average Mortality		
		%	(Hours)
1- 2	7.0	0- 2	7.0
3- 6	14.0	3- 4	17.0
7-10	21.0	5- 8	19.0
11-16	28.0	9-12	24.0
17-20	37.0	13-21	25.0
		21+	28.0

TABLE III

DURATION OF ECLAMPSIA AND MORTALITY

Time from first convulsion to delivery	Average mortality
(Hours)	%
0- 2	7.0
3- 4	17.0
5- 8	19.0
9-12	24.0
13-21	25.0
21+	28.0

criteria for severe eclampsia is the presence of one or more of the following:

1. Coma.
2. Temperature over 39° C.
3. Pulse rate over 120.
4. Respiratory rate over 40.
5. More than ten convulsions.
6. Cardiovascular impairment (pulmonary edema—persistent cyanosis—failing B.P.—etc.)
7. Failure of treatment to:
  - a. Stop convulsions.
  - b. Increase the urinary output to at least 700 cc/day.
  - c. Prevent or decrease coma.
  - d. Produce blood dilution.

The aim in the treatment of eclampsia is to promote adequate renal function, to control convulsions, and, of less importance, to lower blood pressure. The following measures are instituted to accomplish these aims.

#### GENERAL TREATMENT

The patient is placed in a dark, quiet room with an attendant constantly present. A mouth gag should be prepared for insertion between the teeth during convulsions to prevent injury to the tongue. Facilities for aspiration of mucus from the pharynx and trachea should be available. Recordings of blood pressure, urine volume, temperature, pulse, respiration, and response to treatment should be made at least hourly. During the period of convulsions or coma nothing is given by mouth; the stomach should be aspirated if the patient is vomiting. After control of convulsions or recovery from coma, fluids in the form of water and fruit juices may be given. It must be remembered, however, that normal gastric activity is reduced during labor, hence fluids by mouth should not be pushed.

#### PROMOTION OF RENAL FUNCTION

An indwelling catheter is inserted in the bladder and hourly urine outputs are recorded. The rapid intravenous injection of hypertonic glucose solution, 500-1000 cc. of 20 per cent glucose, is the most effective method of stimulating urinary output since it is the only rapid method by which the abnormal fluid exchange between the vascular system and the tissues can be reversed. This injection may be repeated at six to eight hour intervals in order to sustain the initial diuresis. The ordinary diuretic preparations are completely valueless in stimulating renal function in eclampsia.

Following the administration of glucose with the resultant diuresis, the patient may be relieved of cerebral symptoms (cerebral edema) and revive from coma. If this occurs the prognosis is definitely improved.

#### CONTROL OF CONVULSIONS

Prompt sedation and control of convulsions is an important step in treatment. In our hands a combination of drugs has been more effective than any single one, at least two of the following being most commonly administered: magnesium sulfate 50 per cent, sodium luminal, chloral hydrate, or morphine sulfate. An initial, deep intramuscular injection of 10 cc. of 50 per cent magnesium sulfate will aid in controlling convulsions, sedating the patient, and lowering blood pressure. This is repeated in 2 cc. doses after each convolution or until a total of 20 cc. has been given in a 24 hour period. Sodium luminal 0.3 gm. (5 gr.) subcutaneously at eight to twelve hour intervals will maintain sedation. The initial effect of this drug is slow to appear but the sedation produced is of long duration. Chloral hydrate 2 gm. (30 gr.) in 100 cc. starch water may be administered rectally every six to twelve hours. While morphine has been extensively utilized in eclampsia it has certain pharmacological effects which may be disadvantageous in certain cases: the production of acidosis, concentration of the blood, a decrease in urine volume, and an increase in intracranial pressure.

#### CONTROL OF BLOOD PRESSURE

Depression of blood pressure is not one of the important factors in the treatment of eclampsia; in fact, even a moderate fall in pressure may result in a reduction of urine output. This has been demonstrated conclusively both in experimental animals and in man using the barbiturates and veratrum viride (one of the drugs formerly used extensively in the treatment of eclampsia). The blood pressure in the average patient with eclampsia is rarely elevated over 180-200 systolic, and since the vessels are normal vascular accidents are uncommon. Sedation which will control convulsions will in most cases reduce blood pressure to a safe level.

#### TERMINATION OF PREGNANCY

Although termination of the pregnancy is the decisive step in the treatment of eclampsia, ill advised attempts at delivery at an inopportune time may result in the death of a patient who otherwise might have survived. While it may in certain instances become necessary to deliver promptly a severe eclamptic who is responding poorly to treatment, the mild cases can usually be carried until labor can safely be induced. Evaluation of the size of the infant, the pelvis, and the condition of the cervix during the initial period of treatment will aid in the decision as to how delivery will be accomplished. Delivery from below is preferable if the cervix is "ripe" and if there are no contraindications. Cesarean section should be considered only in the patient in whom there is a contraindication to delivery from below (cephalopelvic disproportion).

or in the face of severe eclampsia in a patient with a long, closed cervix. Initial treatment by delivery by any means without a preliminary period of medical control of the disease is associated with an alarming maternal mortality, hence control of convulsions and reestablishment of renal function must precede delivery.

#### SUMMARY

The recognition of the earliest signs of pre-eclampsia and the prompt institution of adequate treatment will in most cases prevent the progression to severe pre-eclampsia and eclampsia with a resultant decrease in maternal and fetal mortality. The

treatment of pre-eclampsia is directed toward maintenance of normal renal function and reversal of the abnormal fluid exchange between blood stream and tissues.

The most important factors in the control of eclampsia are the use of hypertonic glucose solutions to reestablish normal renal function and to relieve cerebral edema, and sedation to control convulsions. While delivery is important, the survival rate can be increased by "obstetrical management," that is, a period of medical control followed by termination of the pregnancy at a time when it is least dangerous for the mother.

## PENICILLIN IN EAR, NOSE, AND THROAT INFECTIONS

Louis R. Haas, M.D.

Pittsburg, Kansas

It is a property of all new medical knowledge that it must go through two stages: first, the accumulation of statistics, and second the achievement of perspective. Because of the comparatively short time that penicillin has been available, we are just beginning to enter upon this stage of perspective. Let us consider this agent, in this resume, from the point of how and why it acts or fails, as the case may be.

*Bacteriology:* Both penicillin and the sulfonamides are bacteriostatic. Penicillin acts by interfering with the normal mitotic processes of the bacteria. To be effective it must be present in sufficient concentration and in actual contact with the organisms for a time, variously estimated, but certainly not less than two and one half hours.

In a general sense penicillin is active against gram positive organisms. Of the organisms that we are most likely to encounter penicillin is effective against staphylococcus, streptococcus, and pneumococcus. But it is not effective against all strains of even these organisms, as has been proved in vitro and in vivo. There are strains of staphylococcus that will grow in the presence of even large quantities of penicillin. Further, organisms can become penicillin resistant.

The anaerobic streptococcus and the Lancefield B Group, so often encountered in ear, nose, and throat infections, are resistant to the sulfonamides but are sensitive to both tyrothricin and penicillin (S. J. Crowe and A. T. Ward<sup>1</sup>). The colon group is resistant to penicillin but sensitive to the sulfonamides, while proteus and the Friedlander organism are resistant to both.

Against fungi, penicillin is not effective. Indeed it may be one of the causes (penicillium) of an

itching ear. Sulfanilamide is the antibiotic effective against most of the fungi, except monilia, which we encounter (Fred T. Wolf<sup>2</sup>).

*Pharmacology:* Penicillin is a very soluble and easily diffusible substance. Therefore it can reach the lymph and body fluids in high concentration rapidly after intramuscular or intravenous injection. But since it is rapidly excreted, the blood level drops rapidly after three hours. It is now possible, but still too expensive, to use penicillin by mouth. Here the blood levels do not, apparently, reach quite so high a level, but are maintained somewhat longer than after injection.

While the partition of sulfanilamide, sulfapyridine, or sulfadiazine between the blood and spinal fluid is as 2:1 (Henry L. Williams<sup>3</sup>), penicillin does not reach the spinal fluid in sufficient concentration to be effective except by intrathecal injection. But when so given it does not disappear from the spinal fluid for over 30 hours.

*Toxicity:* When Sydenham declared, "Opium is like the finger of God, it can cure or it can smite", he declared a generalization applicable to all drugs until the discovery of penicillin. Ehrlich developed the concept of "therapeutic index" ( $\frac{MLD}{MED}$ ) and felt that no drug was safe unless this was at least ten. With penicillin we have a new era of therapeutics. Since mitosis (the time penicillin enters and inhibits the cell) is so rapid in the invading organisms as compared with the normal tissue cells, the therapeutic index of penicillin is unbelievably high. From my own experience I can recall only one case, and from conversations and the literature can find not over a half dozen cases where there were untoward effects. And these all seemed to be in the

nature of an allergy, possibly to some impurity in the solution rather than to the penicillin itself.

**Pathology:** In infection there is first an acute stage during which the invading organisms are literally swimming in the lymph and intracellular fluids. Then there is a subacute or chronic stage in which only the more virulent organisms survive the immunological reactions of the body. These organisms now invade the glands and deep tissues and usually a fibrotic wall is thrown up around them. This is nature's way of limiting the infection. Unfortunately, it is also her way of protecting the organisms from the antibiotics. When an infection spreads beyond this barrier, it does so by going through the first stage of fluid invasion again. The process in bone is not vastly different. To be sure there are sequestra et cetera, but the general principles are the same.

**Application:** From these facts we should be in a position to handle penicillin intelligently.

1. The organism must be penicillin sensitive. In chronic infections this may mean cultures, both aerobic and anaerobic, and cultures tested for their resistance to the various antibiotics.

2. We can hope to get at the organisms only if they are not as yet walled off. After that all that we can accomplish is to prevent spread of infection. If a walled off infection does subside it is good luck rather than good judgment. The natural immunological forces of the body come to our aid. This might be a dangerous and even fatal thing to count on too heavily.

3. Penicillin will not replace surgery. It will decrease the necessity for it and become invaluable as an adjuvant. For example, in infections of the face and frontal bones (Wm. M. M. Kirby and Virgil E. Hepp<sup>4</sup>), infections that in many reported series carried mortalities as high as 80 per cent, extensions are now prevented and most of the cases are operated upon with uneventful recoveries. In this particular type of involvement it is probably wise to continue penicillin therapy for three or four weeks

pre-operatively and a little longer than seems necessary post-operatively.

4. Locally, penicillin has been rather disappointing. This is probably because of the difficulty of reaching all the organisms and of keeping the drug in contact with them sufficiently long. Here tyrothricine which is effective almost on contact is far superior. (Henry L. Williams<sup>5</sup>). In the Proetz displacement treatment of sinusitis, the results with penicillin are not satisfactory. In sinusitis the results are exactly what would be expected. Sinuses that will clear with irrigations of saline will clear with those of penicillin. Chronic sinusitis requires surgery. The results are parallel to those in chronic ear infections. (I. Jerome Hauser and Walter P. Work, MC, Aus<sup>5</sup>).

In the local treatment of chronic middle ear suppuration (EG Collins and KEA Hughes, RAMC<sup>6</sup>) it is easier to change the bacterial flora than to clear up the suppuration.

In infections of the bronchial tree and in bronchiectasis the results are again just what one would expect. In acute infections some relief has been obtained. In bronchiectasis, while the penicillin is maintained in the cavities for as long as twenty-four hours, the results are transient. However, even such results may be of great advantage in a tracheotomized youngster, or in a patient being prepared for lobectomy or pneumonectomy (Gabriel Tucker and Joseph Patkins<sup>7</sup>).

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The American Nurses' Association, meeting in Atlantic City in September, prescribed a new pattern of relationship among nurses and hospitals. A report of the meeting, printed in the November 1946 issue of Hospitals, contained the following outline under the heading Nurse Aides:

"The directors and House of Delegates approved a statement on this subject which included the following points:

"That with the advice of educational authorities, nurses are qualified to do so and should assume the initiative in directing 'practical nurse' education.

"That schools for such trainees should be set up in

an educational environment rather than as part of a service program.

"That the program should be in the nature of adult education, and that only those students be accepted who will be eligible for licensure at the end of training.

"That schools be organized as an entity, rather than as a subdivision of some other department.

"That when training is provided in vocational schools it be given independently of home economics or trade and industry control.

"That qualified nurses serve as director, instructor of nursing and supervisors, and that properly supervised practice fields be provided."

## THE TREATMENT OF CORONARY OCCLUSION\*

Hughes W. Day, M.D.

Kansas City, Kansas

The treatment of coronary thrombosis is not a new subject. It is, however a very timely one, for coronary occlusion is a disease seen by all physicians irrespective of their type of practice. James Herrick stands out as one of the early clinicians who endeavored to make the medical profession conscious of the symptoms produced by closure of a coronary artery. Early last year in the American Heart Journal, he described his first case.<sup>1 2 3</sup> It was the year 1910, the scene a bedroom in a wealthy Chicago home. Herrick described the typical symptoms as we know them today and then added "the patient was a slender man, active, and head of a large banking firm. He had had a midnight meal, and a bottle of beer. About an hour later, he was awakened with severe pain. Dr. Bremmerman, his physician, asked me to see him, and also Dr. John B. Murphy. Dr. Murphy believed that there was no subdiaphragmatic accident but wondered about an acute pneumothorax. I felt not. The dyspnea was less than one would expect. So threatening was the condition that we called a son in New York telling him to hurry home.

"At the request of the family, Dr. Murphy and I stayed that night in a big bedroom with twin beds. Murphy would whisper, 'Herrick, are you awake? Say, are you sure about no pneumothorax?' A little later from my bed, 'Murphy, do you think this might be an acute pancreatitis?' We got up once or twice during the night to see the patient. He expired at 4 a.m. I was unable to be present at the autopsy which was performed by Dr Hektoen. He called me on the telephone and my reply was, 'Look for a clot in the coronary artery. If you don't find that, find a perforated gall bladder or a perforating ulcer, hemorrhagic pancreatitis, hemorrhage into the adrenals, strangulated hernia, ruptures pleura or any other accident you know about.' He thanked me for giving him such a great variety to choose from. That night he called me. 'The clot was in the coronary artery alright but how did you guess it?'"

Thirty-five years have passed since Herrick saw that patient. In the light of our present knowledge, we are more familiar with this disease picture and with its pathology. I shall not discuss either this evening, except to say that our present pathological teaching emphasizes that coronary occlusion is produced by the closure of a ramification of a coronary artery by thrombus, embolis, or the deposition of atheromatous material.

It is impossible to discuss the intelligent treatment of acute coronary occlusion without speaking briefly of the treatment of angina pectoris, for the same basic principles of therapy must be used in both. The pain of angina pectoris, fleeting in character, is believed due to spasm of the athero-sclerotic coronary arteries and is, therefore, just a forerunner of the severe episode which we describe as coronary thrombosis or occlusion. In relieving anginal attacks, three great factors must be considered, namely Work, Worry, and the Weather. Beneath all our efforts—drugs, rest, or psycho-somatic medicine—we are endeavoring to keep coronary spasm at a minimum and coronary circulation at a maximum. Work (or effort), Worry (or anxiety and nervous tension) and the Weather (cold, strong winds) all precipitate anginal attacks by precipitating coronary spasm.

Therefore, in treating a patient with sudden closure of a coronary vessel and with resultant anoxemia of that portion of the myocardium beyond the occlusion, our purpose must be two-fold: Namely, the relief of pain and the relief of spasm. The relief of pain has been the mission of the physician through the ages and I know of no better drug than morphine. It must be used generously and often, allaying both pain and restlessness. I prefer to give it up through the fourth day at least. Because of generalized coronary spasm in the early hours of the disease, we employ Papaverine gr.  $\frac{1}{2}$ , or Aminophyllin gr.  $3\frac{3}{4}$  intravenously on admittance and may repeat it during the first 24 hours. Atropine in fairly large doses gr.  $1/50$  to gr.  $1/75$  administered with the first dose of morphine is very helpful in relieving cardiac irritability and moderate doses may be used over the first 48 hours. It seems to have one undesired action, however, necessitating catheterization.

The problem of premature contractions is best dealt with by the use of quinidine varying from 6 to 12 grains a day and in the rare case which develops paroxysmal ventricular tachycardia large doses are needed up to as high as 60 grains. Mecholyl is of no value in this condition. Bed rest is essential and we prefer a patient to remain quiet for at least three weeks, generally allowing them up in a chair for short intervals by the end of their fourth week. All patients with satisfactory progress are allowed to use a commode with help after the fifth hospital day.

Considering the treatment of coronary occlusion under the factors Work, Worry, and the Weather, I have this to say under the subject of work or effort. The only practical point to realize is that effort is

\* Presented to Staff of Providence Hospital, Kansas City, Kansas, May 15, 1946.

lessened for the coronary patient if he is gently lifted to a commode for bowel movements than allowed to endure the torturing ordeal of straining with an enema on a bedpan. We also keep our patients on a 1200 calorie diet, and employ Petrolagar to insure a soft stool. Enemas are not prescribed.

Under the factor Worry or anxiety, our entire rational of therapy must be considered. These patients are seriously ill but are equally seriously frightened, and we must not forget that worry produces coronary spasm. Therefore, I believe that often our best results are secured in those cases that we "treat" the least. Patients abhor needles and the use of intravenous preparations beyond the immediate period of shock is not necessary. Concentrated glucose may of itself produce spasm and in our judgment should not be used.

Oxygen is a valuable aid in the early course of the disease. It relieves anoxemia, irritability, and pain. But, a frightened patient, terrified by the closeness of the tent and the cold of the atmosphere, is a patient in which worry and the weather may be producing further coronary spasm. Oxygen by nasal catheter 3-4 liters and a warm patient is the best method of administration except in the occasional patient who is able to relax and sleep in an enclosure of canvas and cellophane.

In our first slide I have listed the common useful medications in this disease.

1. Morphine and Atropine
2. Papaverine
3. Aminophyllin or Glucophyllin
4. Quinidine
5. Digitalis (Useful only in decompensation.)
6. Ipral Calcium

#### Serious Complications

1. A-V Heart Block
2. Ventricular Tachycardia
3. Pneumonia and Infarction
4. Renal Suppression
5. Hiccoughs

Frequently serious complications arise such as varying degrees of heart block. This requires no

definite intervention unless Stokes-Adams syncope occurs and this is best treated with adrenalin or metrazol.

Paroxysmal Ventricular tachycardis is a very serious complication and large doses of quinidine are indicated immediately. Pneumonia is best handled with penicillin and renal suppression responds as a rule to increased fluid intake and a compensating rise of bold pressure. Hiccoughs are exceedingly difficult to control. Drugs employed are Benzyl Benzoate, Sedation, Hoffman's Anodyne, Carbon Dioxide inhalations (not without danger), Cocain sprayed into the naso-pharnys, and more recently Curare.

There have been several short reports on the use of Vitamin E in the literature lately and we have given Abbott's Natopherol in dosages of 150 mgm. daily to approximately ten patients. It is difficult to evaluate results but a few patients felt that attacks of angina pectoris were lessened in severity and frequency.

When the patient leaves the hospital we advise them to

1. Use no tobacco for 1 year.
2. Limited activity for six weeks.
3. Light work in 4 to 6 months.
4. Avoid exertion and cold inclement weather.
5. Avoid nervous tension.
6. Nitroglycerine gr. 1/200 t. i. d. for 8 to 10 months.
7. Do not gain weight and do not retire from business.

Posterior coronary occlusion carries a somewhat better prognosis than anterior occlusion, but the ultimate recovery of the patient is enhanced by intelligent medical care and sincere cooperation from the patient.

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Nephroptosis is one of the common conditions which produces mistaken symptoms of an acute abdomen, and therefore can be recognized if a proper history is obtained and a physical done. This is most commonly found in long waisted and skinny individuals. Usually, after any pathologic condition is removed and the patient gains in weight, the so-called floating kidney will become more normal due to the fatty pads deposited around it. The treatment is one of instituting proper drainage of the kidney, usually by elevation of the feet and pelvis, allowing the kidney to resume its normal position. If infection is present, the institution of increased fluids and

urinary antiseptics is indicated. Naturally bedrest is conducive to rapid convalescence of the patient suffering from this complication.

Urethritis is most commonly associated with either pyelitis or cystitis or both. Usually the treatment instituted for either will suffice for the correction of this complication. I doubt if ureteral catheterization should ever be attempted for the correction of this condition unless there are definite obstructive signs and symptoms, and only then if the patient's hyperpyrexia cannot be controlled otherwise.—J. Henry Goode, M.D., J.M.A., Alabama, August, 1946.

### **Urology Award**

The American Urological Association has announced its annual offer of an award not to exceed \$500 for an essay or essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been in specific practice for not more than five years and to residents in urology in recognized hospitals.

The selected essay or essays will be presented on the program of the meeting of the American Urological Association to be held in Buffalo, New York, June 30-July 3, 1947. Details of the contest may be secured from the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, who announces that essays must be in his hands before May 1, 1947.

### **Penicillin for Bacterial Endocarditis**

Penicillin has been shown to be an effective agent in preventing one of the most deadly forms of heart disease, subacute bacterial endocarditis, according to an announcement made recently by the American Heart Association. Research by the Council on Rheumatic Fever of the American Heart Association has shown that penicillin is of definite value for persons suffering from rheumatic fever or rheumatic heart disease who must undergo tooth extraction or any operation on the upper respiratory tract.

In outlining the use of the drug in such cases, Dr. Homer F. Swift, chairman of the council, stressed the need for national education on penicillin prophylaxis and asked the cooperation of the medical and dental professions in urging penicillin treatment for those who would definitely benefit from its administration. It has also been found, he said, that the administration of penicillin in large doses and over a long period of time, is beneficial if the disease develops.

### **Millionth Baby Under EMIC Program**

Somewhere in the United States, on or about Armistice Day, the millionth baby under the Emergency Maternity and Infant Care program was expected to arrive, according to figures released recently by the Children's Bureau, which keeps a record of the amounts spent under the program. So far expenses of the program, now in its fourth year of operation, approximate \$100,000,000. In addition to the babies already born, another 100,000 are on their way.

The Children's Bureau has compiled statistics on the program and announces that an estimated 19,000 babies have been born in Kansas under provisions of the E.M.I.C. regulations since the program went into effect here in May, 1943, placing the state in 19th position in number of births. New York, with 87,700 births, records the highest number, with California recording 73,000 and Pennsylvania 60,400.

This care is now costing the government about \$100 for a maternity case and \$65 for an infant's care. In a few cases with complications, the bill runs to well over \$1,000. The amount paid covers the cost of maternity care, including prenatal care, delivery, and care for six weeks after the baby's birth. Doctor, hospital and nursing bills are paid, including those for consultation and laboratory services at rates established under each state plan. Similarly, the medical and hospital bills are paid for the care of a sick baby.

### **Plan Attack on Cancer**

Twenty-four physicians representing 14 medical schools met with the National Advisory Cancer Council on Nov-

ember 7 to plan an attack on cancer from the angle of medical education. These men are members of a special committee appointed to advise the council on the place of cancer in the medical school curriculum, putting into operation one phase of the accelerated cancer control program outlined last spring by the Committee on Cancer Facilities and Services of the National Advisory Cancer Council. Dr. Frank E. Adair, president of the American Cancer Society, heads the new committee.

### **Congress of American College of Surgeons**

The first post-war congress of the American College of Surgeons will be held in Cleveland, Ohio, December 16-20, 1946, with a program of operative and non-operative clinics, demonstrations, symposia, panel discussions, forums, medical motion pictures, exhibits and the 25th annual hospital standardization conference.

### **New Separation Criteria for Medical Officers**

A new separation policy designed to speed the separation from service of medical department officers, with the exception of those in certain critical categories, went into effect November 1, it was announced recently by the War Department, applying especially to those who have requested relief from active duty at the earliest possible time. Also included are those who are graduates of the Army Specialized Training Program with the prescribed length of service in active commissioned duty.

No change is made in the criteria for non-specialist medical corps officers, who are required to complete 24 months of service, but provision is made for all except those definitely excepted to be separated so that their period of terminal leave will be included in the over-all period of service.

Excepted from general provisions are medical corps officers with primary or secondary classifications in certain military occupational specialties, and who are assigned to duties utilizing their specialties. Such officers may be separated upon completion of 36 months' service.

Until people as a whole are educated to the point where they will cease to wait for pain, weakness, or fear to drive them to their physicians, preventive medicine will continue to be the backward child of medical practice.—Edward J. Stieglitz, M.D., *A Future for Preventive Medicine*, the Commonwealth Fund, 1945.

The birth rate in Kansas during August set a new high for any month during the past ten years, showing a total of 3,537, 1,796 males and 1,741 females. Hospital deliveries totalled 3,196.

### **EXECUTIVE OFFICE TO MOVE**

After January 1, 1947, the address of the Executive Office of the Kansas Medical Society will be

512 New England Building  
Fifth and Kansas Avenue

Topeka, Kansas

## PRESIDENT'S PAGE

To the Members of the Kansas Medical Society:

Everyone who has visited the central office of our Society in the past few years has left it feeling anything but proud of its physical aspects. Space has been limited sadly for both work and filing, and our stenographers have worked in a room without windows or daylight.

President Callahan was much disturbed by the situation and at his request Mr. Ebel and I began the difficult search for new quarters a year ago. On my assumption of duties as president at the Wichita meeting, a promise was made of a new central office during my term of office.

It is a source of much pleasure to announce the removal of the central office and the Journal this month to large adequate offices in the New England Building, Suite 512. The Kansas Medical Society with its varied activities increasing every year has been forced to increase its full time staff and now is providing good working conditions for all its employees.

Oliver Ebel and his staff will be most happy to welcome you to your new home whenever you are in Topeka.



H. M. Miles  
President

## EDITORIALS

### First Anniversary of K.P.S.

On the eve of the first anniversary of Kansas Physicians' Service, the medical society may look back with some pride at its accomplishments. The first group was enrolled during December, 1945, and protection became effective on January 1, 1946.

As was expected, enrollment during the first six months was naturally slow and was further retarded because of necessary reorganization in the business office. And yet there are, as of December 1, 1946, 13,677 persons protected by this voluntary non-profit prepaid medical care plan in Kansas. Almost 3,000 enrolled in the last 30 days. Financially also, this has been a good year. It is now proposed that the entire indebtedness to the medical society, originally made on a two-year loan, will be repaid before the state meeting in May.

The Board of Directors of Kansas Physicians' Service is greatly pleased with the splendid co-operation of the medical profession. At present 924 Kansas doctors have signed contracts to participate in this program and additional cards are being received daily. Upon considering the physicians who, by reason of retirement or institutional practice, etc., would have no interest in participation, it will be seen that virtually all practicing physicians in Kansas have already signified their cooperation.

The medical profession has cooperated also in actual enrollment. In each city where an intensive enrollment program has been conducted, the medical profession has met to discuss ways in which assistance could be given. Announcements have been published in newspapers stating local approval of the plan. Individual doctors have called on employers, explaining the purposes of this program. Enrollment representatives have been assisted by the medical profession in many ways.

It is cooperation of this type that has given Kansas Physicians' Service an experience that is unique among the medical care plans of the nation. It is this type of cooperation that creates public confidence in the program. As long as the public understands that the medical profession is in favor of Kansas Physicians' Service, enrollment will continue to accelerate. Already enrollment is being conducted in rural areas, and in at least one county public interest in this program was responsible for procuring a resident physician.

The Executive Committee wishes to thank the medical profession for its patience regarding claims. This has been a tedious and difficult task. As the

committee gains in experience, efficiency in this portion of the work will be greatly increased.

In general, the Kansas Medical Society takes pride in the achievements of Kansas Physicians' Service during its first year of operation. The years following will see this public service project growing to become one of the major items in the overall public relations program of the Kansas Medical Society.

### The Outlook for Influenza

(Editor's Note—The following editorial, of particular interest at this season of the year, is reprinted from the October 31, 1946, issue of the New England Journal of Medicine.)

In a recent paper the Commission on Acute Respiratory Diseases<sup>1</sup> formulated a theory concerning the periodicity of influenza. It is based on published data concerning excess annual death rates from influenza and pneumonia since 1920 and on more precise information concerning the occurrence of epidemics of influenza A and B since 1932.

According to these workers, the sixteen widespread epidemics of influenza that occurred in the United States between 1920 and 1944 can be accounted for on the basis of two specific recurrent infections. Influenza A appears to have a cycle of two or three years, and influenza B a cycle of four to six years. They claim that no other influenza viruses have caused *widespread* epidemics in this country during the past twenty-five years. On the basis of this formulation, the probability of occurrence of future epidemics has been forecast within certain time limits, although exact predictions are not possible.

Specifically, the experience with the presumptive epidemics of influenza B is limited because the cycle is longer than that with influenza A and only a small number of past observations are reliable. The theory offered by the commission called for a widespread epidemic before the summer of 1946. At the time when the paper was written, there had been numerous small outbreaks of this infection that might have represented a return of influenza B five years after the previous epidemic, and there was insufficient evidence to indicate that this disease had caused an epidemic in a true sense. Only slight increases in the gross admission rates for respiratory diseases had occurred in the whole United States Army in the continental United States, although small outbreaks of influenza B occurred in certain units. An influenza epidemic, however, occurred toward the end of 1945 that was roughly comparable in extent to the epidemic of influenza A that occurred in December, 1943.<sup>2</sup> For the country

as a whole a rise in the occurrence of influenza began about the middle of November and reached a peak during the week ending December 22, with a definite falling off in the next two weeks. This epidemic, which involved nearly all geographic areas of the United States and also occurred in other countries, was definitely identified as being due to influenza B in all areas.

It was found that in the past twenty-seven years, seven of the eleven epidemics of presumptive influenza A occurred at an interval of two years and that the remaining four had a three-year interval. On the basis of that experience, there was more than an even chance that influenza A would reappear during the winter of 1945-1946. If influenza failed to occur in that season, the probability that it would appear in the following winter was even greater.

Influenza A was identified in isolated cases during and after the epidemic of influenza B that occurred last December. Small isolated outbreaks were recognized, but no definite epidemic of influenza A occurred. If the theory proposed by the commission is correct, the occurrence of an epidemic of influenza A during the coming fall and winter is almost a certainty. Since the recognized epidemics of influenza A and B in New England have occurred during December or January, an epidemic of influenza A may be expected during those months.

The etiology of the great pandemic of 1918 is not known. Predictions regarding the future occurrence of such a pandemic, if it was caused by an agent other than the virus of influenza A or B, cannot, therefore, be made at the present time.

Considerable information has been accumulated in recent years concerning preventive vaccines against influenza-virus infections, and the subject matter has been given considerable publicity both in the lay press and in the literature distributed by pharmaceutical firms. Physicians will have considerable difficulty in deciding whether or not such a vaccine should be given to any individual or group. In arriving at a decision, the known facts concerning the available vaccines, their efficacy and the untoward effects to be expected should be taken into consideration.

The influenza vaccines now available are prepared from fertile hens' eggs. After a stated period of incubation the eggs are inoculated with living influenza virus, which is then allowed to grow in the eggs—usually for two days. The allantoic fluid from these embryonated eggs is then harvested, and the virus contained in this fluid is concentrated by one of a number of methods and subsequently inactivated either by formalin or by other means, a pre-

servative being added. The present vaccines usually contain about equal quantities of influenza A and B viruses, together with a certain amount of egg protein.

Influenza vaccines are now being marketed by several of the leading manufacturers of biologicals in this country. Their products are recommended for subcutaneous injection. The dose is a single injection of 1 cc. for adults, and two doses of 0.5 cc. each given a week apart are recommended for children. For batches of vaccine that produce excessive local or systemic reactions, the dose recommended for children should be used in adults as well.

The optimum protection to be expected from this vaccine, which is achieved about two weeks after the first injection, corresponds to the time of the maximum rise of antibody. Little if any protection may be expected within the first week after vaccination. The protection lasts at least three or four months and probably as long as a year or more. Its efficacy in protecting against both influenza A and B has already been fairly well established. The first opportunity to prove the effectiveness of these vaccines in the prevention of influenza B occurred last year. The reports indicate that influenza B was about ten times as frequent in unvaccinated persons as in those who were protected by the vaccines given in the manner suggested.<sup>3</sup> The results in influenza A as observed during the epidemic of 1943-1944 were not quite so good but point to a considerable degree of protection from the vaccine.<sup>4</sup> Generally speaking, the incidence of influenza in unvaccinated persons was two to six times, averaging about three times, as great as that in vaccinated persons of comparable groups. The observations at that time were not all done under the most favorable conditions, and some were undertaken within too brief a period before the peak of the epidemic. Better results can probably be expected with the vaccines presently available if they are used under more favorable conditions and at a sufficient interval prior to the expected occurrence of an epidemic.

Reactions to the vaccine are of two types. One is related to sensitivity to egg protein and may be anything from mild urticaria to severe anaphylactic shock. The sensitization of persons so that they later develop allergic reactions from the injection of vaccine containing egg protein or from the ingestion of egg protein is a possibility, although sensitization of the latter type is probably rare. The second type of reaction is one related to the virus content of the vaccine. Symptoms simulating those of influenza may occur but are usually mild, of short duration and not incapacitating. They attest the efficacy of the virus and, when they occur, offer the best evidence that protection will be af-

forsd. These reactions vary considerably with different batches of vaccine and are more frequent when the full dose is given in a single injection.

It should be borne in mind that the common cold and its complications are not prevented by the use of influenza vaccines, nor is protection afforded against bacterial infections such as streptococcal sore throat or against virus infections other than those caused by influenza.

In general, vaccination against influenza, if undertaken, should be done in the New England area during November or immediately on the first occurrence of typical cases of this disease. In the latter event, less protection may be afforded and those already exposed or who come in contact with the infection soon after inoculation may obtain no protection. Vaccination against influenza is not recommended in allergic persons unless there are special reasons for protecting them and unless it is known that they are not specifically sensitive to egg protein. Skin tests with diluted vaccine may be employed to test for such a sensitivity if vaccination is contemplated. Case histories should be obtained concerning sensitivity to egg protein and also concerning previous vaccination with materials that might contain egg protein. Vaccines against influenza, yellow fever and typhus fever were widely employed, particularly the last, among the armed forces that operated in North Africa and in the Mediterranean Theater, and all of them contained egg protein.

Vaccination is desirable in persons who have previously had severe experiences with influenza and its complications. It may also be recommended for those who are prone to recurrent attacks of upper or lower respiratory-tract infections that persist for a long time after attacks of influenza or the common cold. Large-scale immunization against influenza is recommended among groups in which it is important to minimize the occurrence of absenteeism during the period when epidemic influenza is likely to occur. In department stores, for example, the largest volume of business is transacted in the season when influenza epidemics usually occur. Certain industries that are geared to maximum production at these times might also be hard hit by an epidemic of influenza. In colleges and technical schools, particularly now that they have accelerated programs and much overcrowding, the occurrence of influenza might put the programs entirely out of gear. Under such conditions, large-scale vaccination may be highly desirable, but care should be taken to avoid the inclusion of persons in whom reactions might prove serious.

#### REFERENCES

1. Commission on Acute Respiratory Disease. Periodicity of influenza. *Am. J. Hyg.* 43:29-37, 1946.

2. Prevalence of communicable diseases in the United States. December 2-29, 1945. *Pub. Health Rep.* 61:109-113, 1946.

3. Francis, T., Jr., Salk, J. E., and Brace, W. M. Protective effect of vaccination against epidemic influenza. *B. J. A. M. A.* 131: 275-278, 1946.

4. Commission on Influenza et al. Clinical evaluation of vaccination against influenza: preliminary report. *J. A. M. A.* 124:982-985, 1944.

#### Harry M. Dawdy to Cancer Society

The American Cancer Society has announced the appointment of Mr. Harry M. Dawdy of Topeka as executive director of the Kansas Division of the Society. Mr. Dawdy, formerly director of the Vocational Rehabilitation Division of Kansas, assumed his new duties November 15.

Plans for the creation of this position were made at the time of the reorganization of the American Cancer Society and the resultant reorganization of the state divisions.

#### Miss Neel Resigns

The Kansas Medical Society regrets to announce that Miss Millie Neel, who has been employed by the Society for three years, has resigned her position. She is leaving to marry Mr. Harry Fritz of Beatrice, Nebraska, on December 26. Her services to the Society are deeply appreciated, and the Society is sorry to have her leave. We all wish her much joy.

#### Medical Assistants' Clinic

The first of a series of "clinics" to be presented by the Kansas Medical Assistants' Society will be held at Emporia on Sunday, January 19. This meeting is open to all medical assistants and the doctors who employ them, and other meetings will be held later in different parts of the state.

Round table discussions, designed to bring about a better understanding of the mutual problems of physicians and their assistants, will be a feature of the clinic. Dr. C. L. Merideth of Emporia, chairman of the Kansas Medical Society committee on Medical Assistants, will give a short address during the morning session, beginning at 9:30. Luncheon will be served at 1:00 o'clock, with Dr. David L. MacFarlane, president of Kansas State Teachers College, Emporia, as speaker. A tea at the Merideth home at 3:00 o'clock will complete the day's program.

Reservations may be sent to Lyda Jones, 124 Union Street, Emporia, Kansas.

#### Laboratory for Study of Infectious Diseases

A memorial laboratory for the study of infectious diseases, the eighth building of the National Institute of Health at Bethesda, Maryland, was officially dedicated on October 27 as an expression of gratitude for the sacrifices of 23 members of the United States Public Health Service who have died in line of duty.

The laboratory will be used for intensive research on Rocky Mountain spotted fever, typhus, "Q" fever and other Rickettsial diseases, undulant fever, tularemia, psittacosis, poliomyelitis and other central nervous system viruses, and the common cold. Dr. Charles Armstrong, chief of the Division of Infectious Diseases, will administer the work of the laboratory.

Legislation to abolish the use of the "means test" as a basis for public treatment of active tuberculosis has been passed in Illinois, Kansas, Michigan, New York and Wisconsin. Once such laws are on the books, local acceptance and enforcement are essential. Holland Hudson, Rehab. Service, National Tuberculosis Association.

## MEMBERS

Dr. Norris L. Brookens, formerly of Topeka, has moved to Urbana, Illinois, to join the staff of the Carle Hospital Clinic.

\* \* \*

Dr. Don Wilson, who practiced in Scott City and Tribune before entering the Army medical corps, has announced that he will practice at Paul's Valley, Oklahoma.

\* \* \*

Dr. L. A. Proctor, who entered the Army in 1943, is now on terminal leave and has returned to his home in Parsons.

\* \* \*

Dr. W. J. Feehan, Kansas City, has announced his association in practice with Dr. Philip C. Nohe, who was recently released from the Army medical department. Dr. Nohe was graduated from the University of Kansas School of Medicine in 1942.

\* \* \*

Dr. James A. Butin, who has been practicing with the Johnson clinic in Chanute, has announced the opening of an office for private practice there.

\* \* \*

Dr. C. E. Sheppard, Larned, who has been ill, announces that his practice will be cared for during his illness by Dr. W. R. Brenner, lately on the staff of Fitzsimmons general hospital, Denver.

\* \* \*

Eight physicians and surgeons in El Dorado have announced the formation of the El Dorado clinic. Those in the group are Doctors C. E. Boudreau, R. M. Brian, Floyd E. Dillenbeck, Norman H. Overholser, G. E. Kassebaum, A. P. Cloyes, J. H. Johnson and George W. Hammel.

\* \* \*

Dr. D. S. Klassen, who has been practicing in Hillsboro, has opened an office in Newton.

\* \* \*

Dr. Robert P. Norris is returning to his practice in Wichita after having spent two years in the Army medical corps.

\* \* \*

Dr. Byron J. Ashley, Topeka, leaves Christmas day for Quetta, India, where he will spend six weeks in the cataract clinic of the British central mission hospital. He is one of three physicians from the United States who have been invited to work in the clinic.

### COUNTY SOCIETIES

Members of the Marion County Medical Society entertained members of the Harvey and McPherson county societies at a meeting held in Marion November 6. After the dinner meeting, Dr. Francis A. Carmichael, neurosurgeon, and Dr. George V. Hermann, child specialist, both of Kansas City, Missouri, presented medical discussions. Dr. E. T. Gibbons and Oliver Ebel, Topeka, outlined the plan for care of veterans in Kansas.

\* \* \*

Dr. J. D. Jarrott, Hutchinson, was guest speaker at a meeting of the Rice County Society held at Lyons October 24. After the business and scientific sessions, members joined the women of the Auxiliary for a joint social hour.

The Sumner County Medical Society was host to the Tri-county Society November 14 with more than 75 physicians from Sumner and Cowley counties in Kansas and Kay county in Oklahoma attending. During the early afternoon the doctors enjoyed a golf tournament, after which there was a scientific program and dinner meeting.

\* \* \*

The Crawford County Medical Society met November 19 at the Hotel Besse, Pittsburg. Dr. Harry J. Veatch was in charge of the program and introduced the speaker, Dr. Francis A. Carmichael, Jr., Kansas City, Missouri, who illustrated his discussion of spinal cord lesions with lantern slides.

\* \* \*

All of the members of the Mitchell County Society were present at a meeting held at the Beloit hospital October 29. Dr. C. Omer West of Kansas City held a skin clinic in the afternoon, after which the members of the Auxiliary entertained the group at a dinner at the nurses' home. Dr. West presented a paper during the evening session.

\* \* \*

The regular meeting of the Wilson County Society was held at the Kelley Hotel, at Neodesha on November 18. Dr. F. A. Moorhead presided and introduced the speaker, Dr. C. E. Stevenson, who gave a clinical case history. A general group discussion followed.

\* \* \*

Dr. Earle C. Elkins, of the Department of Physical Medicine at the Mayo clinic, addressed members of the Shawnee County Society at their meeting on November 4. His topic was "Physical Rehabilitation of the Severely Injured, with Special Reference to Neurological Conditions."

### DEATH NOTICES

#### JOHN B. DAVIS, M.D.

Dr. John B. Davis, 77, well known physician of Ottawa, died October 2 after having been in poor health for several years. He received his medical education at the Medical College of Ohio, Cincinnati, graduating in 1894, and then returned to his home at Ottawa to practice. He had retired from active practice several years ago.

\* \* \*

#### GEORGE VIVEN ALLEN, M.D.

Dr. George V. Allen, 74, who had specialized in eye, ear, nose and throat work in Topeka for many years, died October 19. A graduate of the Kansas Medical College, Topeka, in 1898, he practiced in Nebraska before opening an office in Topeka in 1912. During World War I he served in the Army medical corps. He was an honorary member of the Shawnee County Medical Society and was also a member of the American Academy of Ophthalmology and Oto-laryngology.

\* \* \*

#### LESTER LEO WILLIAMS, M.D.

Dr. Lester Leo Williams, 51, a practicing physician and surgeon in El Dorado for the past 25 years, died November 4 after being stricken with a heart attack while traveling through Colorado. He was graduated from the Washington University School of Medicine, St. Louis, in 1920, and began his practice in El Dorado. He was a member of the Butler County Medical Society and was a fellow of the American Medical Association.



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## BOOK REVIEWS

*Modern Management in Clinical Medicine*, By Frederick K. Albrecht, M.D. Published by Williams and Wilkins Company, Mount Royal and Guilford Avenues, Baltimore 2, Maryland. 1238 pages. Prices \$10.

This book was given to me in June to read and review, but since the author intends it for a reference book, it is fitting that it be reviewed in a similar manner. It has been on my desk and has been referred to every day or so, but I confess to not having read it through.

This reviewer is a contentious one and I am repelled by the title. My connotation of the word "modern" takes me back to F. Scott Fitzgerald. I think that "Management in Clinical Medicine" would have been just fine.

Dr. Albrecht should be good and sore at Williams and Wilkins for a poor job of proof reading and make up. It seems a shame to spoil a lot of good material with a few silly errors. The most serious error is the omission of half of the index, which makes the book almost useless as a ready reference. The index begins on Page 1211 with "Loeffler's Syndrome" and seems fairly complete from there on. Perhaps my copy alone is at fault, but it seems a poor one to send to a reviewer. The text is full of errata and the appendix, which seems a little unnecessary anyway, is repeated twice to add to the confusion at the end of the book.

The context is excellent if you can find it. The author is modern enough. He has a good resume of penicillin and a fine chart on the use and dosage of the sulfonamides. The chapter on "Clinical Medicine" is quite complete and especially useful in that he describes many of the unfamiliar techniques, making the book a handy lab manual, and a good source of normal levels for the various laboratory procedures.

In a chapter called "Care of the Ambulatory Patient" there are some instructions and lists that might well be copied for distribution to our own patients. However, his chapter on "Geriatrics" consists chiefly of the consideration of the various enlargements of the prostate and their effects. The chapter on nervous diseases is excellent, well organized and includes many procedures hard to find elsewhere, as are the chapters on diseases of the heart and blood vessels.

I think the book is worth \$10 if it has an index.—*R. H. Greer, M.D.*

\* \* \*

*Narcotics and Drug Addiction*. By Erich Hesse, M.D. Price \$3.75. 219 pages. New York, The Philosophical Library, 1946.

It is difficult for the reviewer to assess this book in all its meanings and implications. Fundamentally this difficulty is probably due to the fact that the author is a professor of pharmacology and biology and focuses his interest largely on the sources of supply, chemistry, pharmacology, and the various uses and abuses of many varieties of drugs of the Eastern and Western worlds. It is true some clinical experiences are illustrated, but these are brief and include mostly the verbalizations of addicts under the influence of various drugs, and a few psychiatric interpretations.

The general public will find this book interesting and it will appeal to the varied prejudices of certain social groups who feel that the answer to the narcotic and drug problem lies in rigid legislation and prohibition. The general practitioner, the psychiatrist, and especially the psychoanalyst will find this book disappointing because of its lack of reference to the more basic pathogenic factors and characteristics of the addiction personality, who

fortuitously or inevitably falls into the use of drugs to supply psychological needs. This lack is probably no fault of the author and properly belongs to the field of psychiatry.

There are several confusing and misleading statements with reference to the harmful effects of the drugs described. The drugs are classified according to pharmacologic rather than psychologic effects, although due credit is given to the nature of the pre-addiction personality in the qualitative and quantitative symptomatology of intoxication. The reviewer finds it difficult to follow the author's arbitrary division of patients suffering from habituation and addiction. There are inaccurate and misleading statements about the old argument between hereditary and environmental factors in addiction—for example in the preface: "Every physician is familiar with the hereditary defects of the children of habitual drunkards, and in recent decades, physicians have had plenty to report about the many injuries caused by nicotine."

Throughout the book there are excellent literary passages about the unrealistic illusions and masochistic surrender of the addict. However, no mention is made except by suggestion of the emotional immaturity and infantile sexuality of the addict and his basic fraudulence with himself and society.

The author contradicts himself in nearly every chapter in venturing to sponsor an overall solution to the problem of addiction. He states that addiction is as old as civilization and that the traffic in drugs is commercially exploited; he adds that the cleverness and dishonesty of the addict and commercial interests have defied all control measures. Yet, paradoxically, he boldly suggests prohibition and cites trite platitudes to support this view. At the same time, he states such measures are often ineffectual. His plug for public education and organized control is commendable, yet clinicians know this is not the real answer. Much more knowledge is needed about personality development and social problems and customs to expect these two measures to work.

The author has an admirable missionary spirit, but in a clinical sense slightsls some of the basic problems, individual and social, of alcohol and barbiturate addiction, the most common addictions in the U. S. Tobacco for some reason is given undue mention. Many research scientists and clinicians would take sharp issue with statements made about deleterious effects of tobacco on page 158—for example being responsible for many functional and physical disorders involving the sexual organs, endocrine glands, etc. On page 159 the author apparently adds further prohibitions to those of Lickint about tobacco, and all physicians should read them.

Aside from the above criticisms, the author has made many astute observations, has probed statistical studies, and, in spite of his moralizing, has given us a good reference book and an excellent bibliography, chiefly from European sources to the neglect of many good American sources.—*Harlan H. Crank, M.D.*

## BOOKS RECEIVED

*The Challenge of Polio*. By Roland H. Berg with introduction by Basil O'Connor. Published by the National Foundation for Infantile Paralysis, New York City. 208 pages.

*Hygiene*. Fourth Edition. By Florence L. Meredith, M.D. Published by the Blakiston Company, Philadelphia. 838 pages. 155 illustrations. Price \$4.00.

*Medical Uses of Soap*. Edited by Morris Fishbein, M.D.

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\**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

Published by J. B. Lippincott Company, Philadelphia. 195 pages. Price \$3.00.

A Surgeon in Wartime China. By Lyle S. Powell, M.D., Lawrence, Kansas. Published by the University of Kansas Press, Lawrence. 233 Pages. Price \$2.50.

### Proposed Amendment to By-laws

The Council of the Kansas Medical Society, in session at Topeka on October 6, 1946, unanimously approved an amendment to the By-laws of the Constitution designed to expedite handling of finances for the Journal of the Kansas Medical Society. The request for this amendment reached the Council from the Editorial Board of the Journal, and the Council recommends the introduction of this amendment at the first meeting of the 1947 House of Delegates.

By-laws, Chapter X—Editorial Board—Section 7.

This section now reads, "Funds of the JOURNAL and other publications shall be accounted in separate ledgers, and shall preferably be maintained in separate banking institutions. Bills for expenditures authorized by the Editorial Board and approved by the chairman of the Board shall be paid by vouchers signed by the treasurer and countersigned by the president and secretary. Surplus funds may be accrued at the end of the fiscal year to reserve accounts within limits established by the House of Delegates or the Council."

This section shall be amended to read, "Funds of the JOURNAL and other publications shall be accounted in separate ledgers, and shall preferably be maintained in separate banking institutions. Bills for expenditures authorized by the Editorial Board and approved by the chairman of the Board shall be paid by vouchers signed by the Chairman of the Board and countersigned by either the managing editor or the business manager of the Journal of the Kansas Medical Society. The Chairman of the Board, the managing editor and the business manager shall be individually bonded for sums not less than \$5,000. Certification of all vouchers written shall be mailed not less frequently than once each month to the president, the secretary and the treasurer of the Kansas Medical Society. Surplus funds may be accrued at the end of the fiscal year

to reserve accounts within limits established by the House of Delegates or the Council."

### Schedule for Refresher Courses

Several changes have been made in the schedule for refresher courses to be presented by the University of Kansas School of Medicine in 1947, so a complete list of courses is presented below:

January 13-16—Physical Medicine.

February 24-28—Pediatrics and Public Health.

March 17-21—Internal Medicine and Dermatology.

March 31-April 4—EENT (Primarily for men in general practice).

April 7-11—Surgery.

April 21-25—Obstetrics and Gynecology.

May 13-15—Nursing Education (for graduate nurses).

June 9-13—Radiology and Cancer.

The University also announces that the School of Medicine, in cooperation with the National Academy of Allergists, will present a course in allergy from May 5 to May 7, inclusive. It is offered on a nation-wide basis, and there will be an enrollment fee of \$50.

### CLASSIFIED ADVERTISEMENTS

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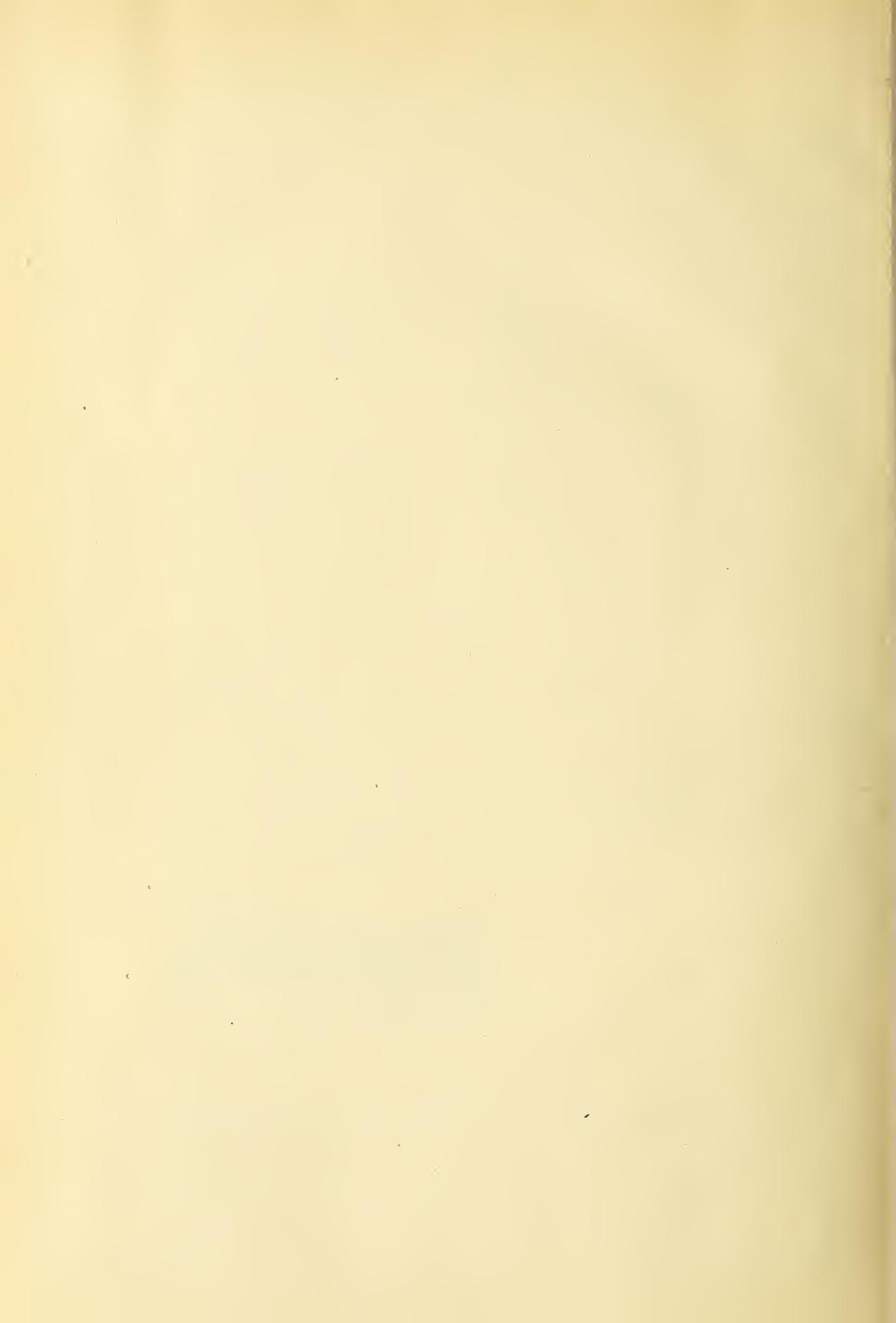
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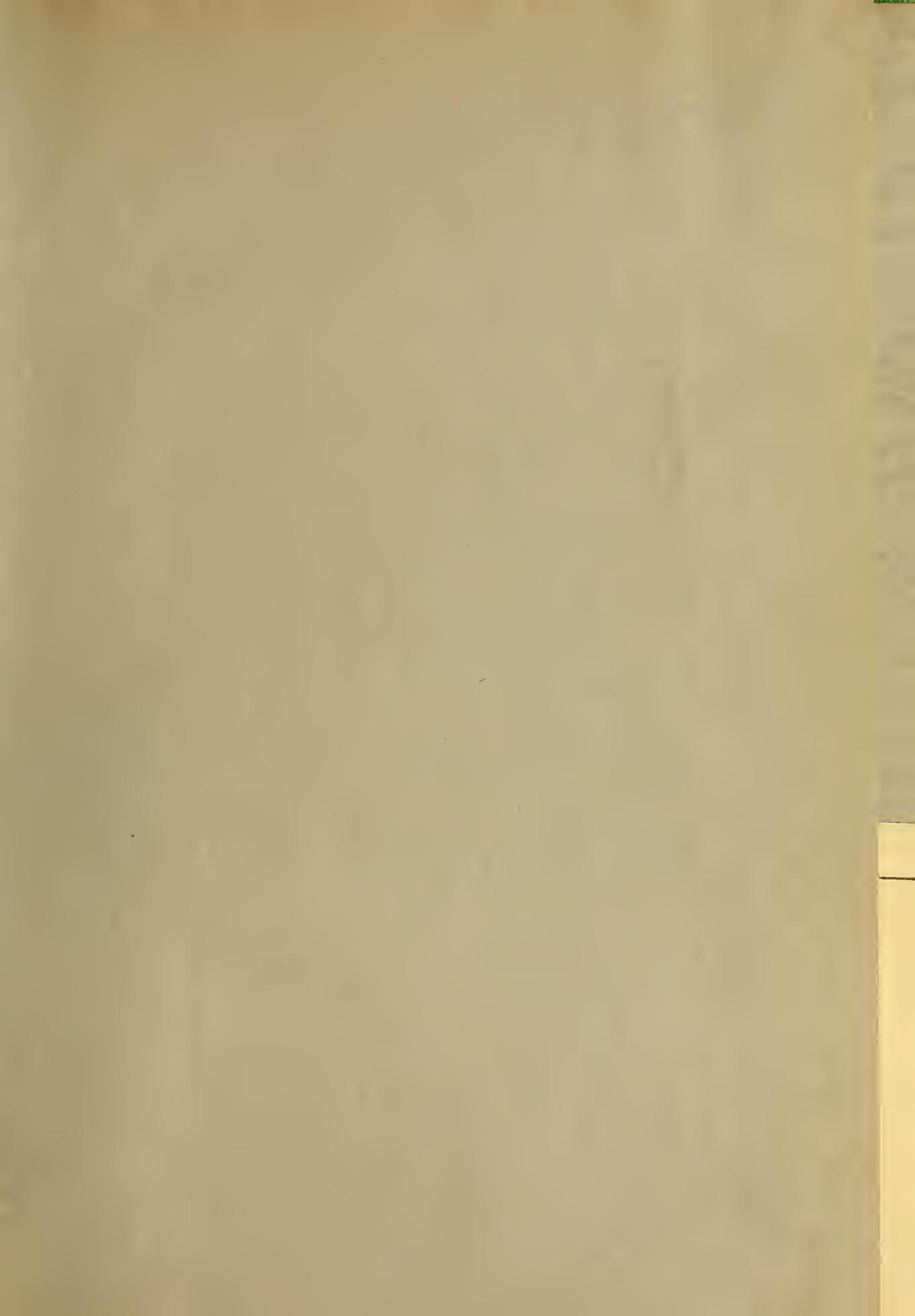
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